Form No. DTMB-3522 (Rev. 10/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN

DEPARTMENT OF TECHNOLOGY, MANAGEMENT & BUDGET

PROCUREMENT

525 W. ALLEGAN STREET
LANSING, MI 48933

P.O. BOX 30026
LANSING, MI 48909

NOTICE OF CONTRACT NO. **071B6600031**

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
UnitedHealthcare Community Plan, Inc.	Dennis Mouras	dmouras@uhc.com
26957 Northwestern Highway, Suite 400	PHONE	VENDOR TAX ID # (LAST FOUR DIGITS ONLY)
Southfield, MI 48033	248-331-4269	4052

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER	DHHS	Todd Smith	517-241-4686	Smitht65@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	517-284-7017	Kingsburyl@michigan.gov

CONTRACT SUMMARY

DESCRIPTION:

Comprehensive Health Care Program – DHHS (Regions 2,3,4,5,6,8,9,10)

INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
Five years	January 1, 2016	December 31, 2020	Three-one year options
PAYMENT TERMS	F.O.B.	SHIPPED TO	
Net 45	N/A	N/A	

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

MISCELLANEOUS INFORMATION

ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION	$5,845,000,000.00

For the Contractor:

Dennis Mouras, CEO
UnitedHealthcare Community Plan, Inc.

Date

For the State:

Tom Falik, Services Division Director
State of Michigan

Date

STATE OF MICHIGAN

STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and UnitedHealthcare Community Plan ("**Contractor**"), a Michigan Corporation. This Contract is effective on January 1, 2016 ("**Effective Date**"), and unless terminated, expires on December 31, 2020.

This Contract may be renewed for up to three additional one year period(s). Renewal must be by written agreement of the parties.

The parties agree as follows:

1. **Duties of Contractor.** Contractor must perform the services and provide the deliverables described in **Exhibit A – Statement of Work** (the "**Contract Activities**"). An obligation to provide delivery of any commodity is considered a service and is a Contract Activity.

   Contractor must furnish all labor, equipment, materials, and supplies necessary for the performance of the Contract Activities, and meet operational standards, unless otherwise specified in Exhibit A.

   Contractor must: (a) perform the Contract Activities in a timely, professional, safe, and workmanlike manner consistent with standards in the trade, profession, or industry; (b) meet or exceed the performance and operational standards, and specifications of the Contract; (c) provide all Contract Activities in good quality, with no material defects; (d) not interfere with the State's operations; (e) obtain and maintain all necessary licenses, permits or other authorizations necessary for the performance of the Contract; (f) cooperate with the State, including the State's quality assurance personnel, and any third party to achieve the objectives of the Contract; (g) return to the State any State-furnished equipment or other resources in the same condition as when provided when no longer required for the Contract; (h) not make any media releases without prior written authorization from the State; (i) assign to the State any claims resulting from state or federal antitrust violations to the extent that those violations concern materials or services supplied by third parties toward fulfillment of the Contract; (j) comply with all State physical and IT security policies and standards which will be made available upon request; and (k) provide the State priority in performance of the Contract except as mandated by federal disaster response requirements. Any breach under this paragraph is considered a material breach.

   Contractor must also be clearly identifiable while on State property by wearing identification issued by the State, and clearly identify themselves whenever making contact with the State.

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

If to State:	If to Contractor:
Lance Kingsbury *525 W. Allegan St. 1st Floor, NE* *P.O. Box 30026* *Lansing, MI 48909-7526* *kingsburyl@michigan.gov* *517-284-7017*	*Dennis Mouras* *26957 Northwestern Hwy.* *Suite 400* *Southfield, Michigan 48033* *dmouras@uhc.com* *(248) 331-4269*

3. **Contract Administrator.** The Contract Administrator for each party is the only person authorized to modify any terms and conditions of this Contract (each a "**Contract Administrator**"):

State:	Contractor:
Lance Kingsbury *525 W. Allegan St. 1st Floor, NE* *P.O. Box 30026* *Lansing, MI 48909-7526* *kingsburyl@michigan.gov* *517-284-7017*	*Dennis Mouras* *26957 Northwestern Hwy., Suite 400* *Southfield, Michigan 48033* *dmouras@uhc.com* *(248) 331-4269*

4. **Program Managers.** The Program Managers for each party will monitor and coordinate the activities of the Contract (each a "**Program Manager**"):

State:	Contractor:
Ashleigh Lipsey (day-to-day) *Michigan Department of Health and Human Services* *Capitol Commons Center* *400 South Pine* *Lansing, MI, 48933* *lipseya@michigan.gov* *Phone: (517) 241-4367*	*Lisa Gray* *26957 Northwestern Hwy., Suite 400* *Southfield, Michigan 48033* *lgray@uhc.com* *(248) 331-4322*

State:	Contractor:
Todd Smith, Buyer (non day-to-day) *Michigan Department of Health and Human Services* *Grand Tower, 12 Floor* *235 South Grand Avenue* *Lansing, MI 48909* *smitht65@michigan.gov* *Phone: (517) 241-4686*	*Lisa Gray* *26957 Northwestern Hwy., Suite 400* *Southfield, Michigan 48033* *lgray@uhc.com* *(248) 331-4322*

5. **Performance Guarantee**. Contractor must at all times have financial resources sufficient, in the opinion of the State, to ensure performance of the Contract and must provide proof upon request. The State may require a performance bond (as specified in Exhibit A) if, in the opinion of the State, it will ensure performance of the Contract.

6. **Insurance Requirements.**

6.1 **Contractor Insurance Coverage.** Contractor must maintain the insurances identified below and is responsible for all deductibles. All required insurance must: (a) protect the State from claims that may arise out of, are alleged to arise out of, or result from Contractor's or a subcontractor's performance; (b) be primary and non-contributing to any comparable liability insurance (including self-insurance) carried by the State; and (c) be provided by an company with an A.M. Best rating of "A" or better and a financial size of VII or better or be provided through an actuarially sound program of self-insurance. Any self- insurance program must be approved annually by the state.

Insurance Type	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 210 07 04 and CG 2037 07 0. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.

Umbrella or Excess Liability Insurance	
Minimal Limits: $5,000,000 General Aggregate	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $10,000,000 Each Occurrence $10,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime Insurance	
Minimal Limits: $2,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

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

Contractor must: (a) provide insurance certificates to the Contract Administrator, containing the agreement or purchase order number, at Contract formation and within 20 calendar days of the expiration date of the applicable policies; (b) require that subcontractors maintain the required insurances contained in Section 6; (c) notify the Contract Administrator within 5 business days if any insurance is cancelled; and (d) waive all rights against the State for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

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

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

All Subcontractors must maintain the insurances identified respective to their Subcontractor classification and are responsible for all deductibles. All required insurance must: (a) protect the State from claims that may arise out of, are alleged to arise out of, or result from a Subcontractor's performance; (b) be primary and non-contributing to any comparable liability insurance (including self-insurance) carried by the State; and (c) be provided by a company with an A.M. Best rating of "A" or better and a financial size of VII or better.

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

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

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

Category I: Health Benefit Managers and Category III: Type A Transportation Subcontractors are required to pay for and provide the type and amount of insurance specified below:

Insurance Type	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 0. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Umbrella or Excess Liability Insurance	
Minimal Limits: $5,000,000 General Aggregate	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	

Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime Insurance	
Minimal Limits: $1,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

Category II: Type A – Administrative Subcontractors dealing with payment decisions are required to pay for and provide the type and amount of insurance listed below:

Insurance Type	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 0. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident	

$500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime Insurance	
Minimal Limits: $1,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

Category II: Type B – Administrative Subcontractors dealing with medical decisions are required to pay for and provide the type and amount of insurance listed below:

Insurance Type	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 0. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.

Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

Type B - Transportation Subcontractors are required to pay for and provide the type and amount of insurance specified below:

Insurance Type	Additional Requirements
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	

7. **Independent Contractor.** Contractor is an independent contractor and assumes all rights, obligations and liabilities set forth in this Contract. Contractor, its employees, and agents will not be considered employees of the State. No partnership or joint venture relationship is created by virtue of this Contract. Contractor, and not the State, is responsible for the payment of wages, benefits and taxes of Contractor's employees and any subcontractors. Prior performance does not modify Contractor's status as an independent contractor.

8. **Subcontracting.** Contractor may not delegate any of its obligations under the Contract without the prior written approval of the State. Contractor must notify the State within the number of calendar days specified in this Section before the proposed delegation, and provide the State any information it requests to determine whether the delegation is in its best interest. If approved, Contractor must: (a) be the sole point of contact regarding all contractual matters, including payment and charges for all Contract Activities; (b) make all payments to the subcontractor; and (c) incorporate the terms and conditions contained in this Contract in any subcontract with a subcontractor. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. Contractor remains responsible for the completion of the Contract Activities, compliance with the terms of this Contract, and the acts and omissions of the subcontractor. The State, in its sole discretion, may require the replacement of any subcontractor.

   Under this Contract, there are three classifications of Subcontractors:

   Category I: Health Benefit Managers

   Health Benefit Managers (HBMs) are entities that arrange for the provision of health services covered under this Contract, with the exclusion of transportation. Health Benefit Managers can include, but are not limited to; Pharmacy Benefit Managers, Behavioral Health Benefit Managers, Vision Benefit Managers and Community Health Workers. The Contractor must request approval of a change of any Health Benefit Manager at least 30 calendar days prior to proposed delegation. .

   Category II: Administrative Subcontractors

   Administrative Subcontractors are entities that perform administrative functions required by this Contract such as claims payment, delegated credentialing, and card production and mailing services. Administrative Subcontractors are classified by function:

   Type A Administrative Subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or another function involving payment decisions.

Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization management, or case-management.

Type C Administrative Subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical decisions. This type of Administrative Subcontractor includes but is not limited to identification care production and mailing services.

The Contractor must request approval of a change of any Administrative Subcontractor at least 21 calendar days prior to the proposed delegation. .

Category III: Transportation Subcontractor

Transportation Subcontractors are entities that arrange or arrange and provide transportation services. Transportation Subcontractors are divided into two types, as follows:

Type A Transportation Subcontractors subcontract with other entities to provide Enrollees transportation to and from health care services.

Type B Transportation Subcontractors are entities or agencies that arrange and provide Enrollees transportation to and from health care services (e.g. social or religious agencies).

The Contractor must request approval of a change of any Type A and Type B Transportation Subcontractor at least 30 calendar days prior to the proposed delegation. of the effective date of the contract with the Subcontractor. The State reserves the right to approve or reject the Contractor's proposed use of any Transportation Subcontractor.

Type B Transportation Subcontractors must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract between the Contractor and Type B Transportation Subcontractor should require these Subcontractors to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage.

9. **Staffing.** The State's Contract Administrator may require Contractor to remove or reassign personnel by providing a notice to Contractor.

10. **Background Checks.** Upon request, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

11. **Assignment.** Contractor may not assign this Contract to any other party without the prior approval of the State. Upon notice to Contractor, the State, in its sole discretion, may assign in whole or in part, its rights or responsibilities under this Contract to any other party. If the State determines that a novation of the Contract to a third party is necessary, Contractor will agree to the novation, provide all necessary documentation and signatures, and continue to perform, with the third party, its obligations under the Contract.

12. **Change of Control.** Contractor will notify, at least 90 calendar days before the effective date, the State of a change in Contractor's organizational structure or ownership. For purposes of this Contract, a change in control means any of the following: (a) a sale of more than 50% of Contractor's stock; (b) a sale of substantially all of Contractor's assets; (c) a change in a majority of Contractor's board members; (d) consummation of a merger or consolidation of Contractor with any other entity; (e) a change in ownership through a transaction or series of transactions; (f) or the board (or the stockholders) approves a plan of complete liquidation. A change of control does not include any consolidation or merger effected exclusively to change the domicile of Contractor, or any transaction or series of transactions principally for bona fide equity financing purposes.

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

13. **Terms of Payment.** The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use. Notwithstanding the foregoing, all prices are inclusive of taxes, and Contractor is responsible for all sales, use and excise taxes, and any other similar taxes, duties and charges of any kind imposed by any federal, state, or local governmental entity on any amounts payable by the State under this Contract.

    The State has the right to withhold payment of any disputed amounts until the parties agree as to the validity of the disputed amount. The State will notify Contractor of any dispute within a reasonable time. Payment by the State will not constitute a waiver of any rights as to Contractor's continuing obligations, including claims for deficiencies or substandard Contract Activities. Contractor's acceptance of final payment by the State constitutes a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still disputed.

    The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor must register with the State at http://www.michigan.gov/cpexpress to receive electronic fund transfer payments. If Contractor does not register, the State is not liable for failure to provide payment. Without prejudice to any other right or remedy it may have, the State reserves the right to set off at any time any amount then due and owing to it by Contractor against any amount payable by the State to Contractor under this Contract.

14. **Stop Work Order.** The State may suspend any or all activities under the Contract at any time. The State will provide Contractor a written stop work order detailing the suspension. Contractor must comply with the stop work order upon receipt. Within 90 calendar days, or any longer period agreed to by Contractor, the State will either: (a) issue a notice authorizing Contractor to resume work, or (b) terminate the Contract or purchase order. The State will not pay for Contract Activities, Contractor's lost profits, or any additional compensation during a stop work period.

15. **Termination for Cause.** The State may terminate this Contract for cause, in whole or in part, if Contractor, as determined by the State: (a) endangers the value, integrity, or security of any location, data, or personnel; (b) becomes insolvent, petitions for bankruptcy court proceedings, or has an involuntary bankruptcy proceeding filed against it by any creditor; (c) engages in any conduct that may expose the State to liability; (d) breaches any of its material duties or obligations; or (e) fails to cure a breach within the time stated in a notice of breach. Any reference to specific breaches being material breaches within this Contract will not be construed to mean that other breaches are not material.

    If the State terminates this Contract under this Section, the State will issue a termination notice specifying whether Contractor must: (a) cease performance immediately, or (b) continue to perform for a specified period. If it is later determined that Contractor was not in breach of the Contract, the termination will be deemed to have been a Termination for Convenience, effective as of the same date, and the rights and obligations of the parties will be limited to those provided in Section 16, Termination for Convenience.

    The State will only pay for amounts due to Contractor for Contract Activities accepted by the State on or before the date of termination, subject to the State's right to set off any amounts owed by the Contractor for the State's reasonable costs in terminating this Contract. The Contractor 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.

16. **Termination for Convenience.** The State may immediately terminate this Contract in whole or in part without penalty and for any reason, including but not limited to, appropriation or budget shortfalls. The termination notice will specify whether Contractor must: (a) cease performance of the Contract Activities immediately, or (b) continue to perform the Contract Activities in accordance with Section 17, Transition

Responsibilities. If the State terminates this Contract for convenience, the State will pay all reasonable costs, as determined by the State, for State approved Transition Responsibilities.

17. **Transition Responsibilities.** Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed two years), provide all reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees. Such transition assistance may include, but is not limited to: (a) continuing to perform the Contract Activities at the established Contract rates; (b) taking all reasonable and necessary measures to transition performance of the work, including all applicable Contract Activities, training, equipment, software, leases, reports and other documentation, to the State or the State's designee; (c) taking all necessary and appropriate steps, or such other action as the State may direct, to preserve, maintain, protect, or return to the State all materials, data, property, and confidential information provided directly or indirectly to Contractor by any entity, agent, vendor, or employee of the State; (d) transferring title in and delivering to the State, at the State's discretion, all completed or partially completed deliverables prepared under this Contract as of the Contract termination date; and (e) preparing an accurate accounting from which the State and Contractor may reconcile all outstanding accounts (collectively, "**Transition Responsibilities**"). This Contract will automatically be extended through the end of the transition period.

18. **General Indemnification.** Contractor 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 Contractor (or any of Contractor's employees, agents, subcontractors, 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 Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable); and (d) any acts or omissions of Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable).

    The State will notify Contractor in writing if indemnification is sought; however, failure to do so will not relieve Contractor, except to the extent that Contractor is materially prejudiced. Contractor must, to the satisfaction of the State, demonstrate its financial ability to carry out these obligations.

    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. Contractor 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.

    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.

19. **Infringement Remedies.** If, in either party's opinion, any piece of equipment, software, commodity, or service supplied by Contractor or its subcontractors, or its operation, use or reproduction, is likely to become the subject of a copyright, patent, trademark, or trade secret infringement claim, Contractor must, at its expense: (a) procure for the State the right to continue using the equipment, software, commodity, or service, or if this option is not reasonably available to Contractor, (b) replace or modify the same so that it becomes non-infringing; or (c) accept its return by the State with appropriate credits to the State against Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

20. **Limitation of Liability.** The State is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

21. **Disclosure of Litigation, or Other Proceeding.** Contractor must notify the State within 14 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving Contractor, a subcontractor, or an officer or director of Contractor or subcontractor, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Contractor's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

22. **State Data.**

    a. Ownership. The State's data ("**State Data**," which will be treated by Contractor 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 individual, such as an individual'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) personal health information ("**PHI**") collected, used, processed, stored, or generated as the result of the Contract Activities, which is defined under the Health Insurance Portability and Accountability Act (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.

    b. Contractor Use of State Data. Contractor 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. Contractor 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 Contractor'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.

    c. Extraction of State Data. Contractor must, within five (5) business days 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 Contractor), an extract of the State Data in the format specified by the State.

    d. Backup and Recovery of State Data. Unless otherwise specified in Exhibit A, Contractor is responsible for maintaining a backup of State Data and for an orderly and timely recovery of such data. Unless otherwise described in Exhibit A, Contractor must maintain a contemporaneous backup of State Data that can be recovered within two (2) hours at any point in time.

    e. 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 Contractor that relate to the protection of the security, confidentiality, or integrity of State Data, Contractor 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 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 Contractor'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 10 calendar days of the occurrence describing the measures Contractor 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 Contractor'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 Contractor 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 Contractor. This Section survives the termination of this Contract.

23. **Non-Disclosure of Confidential Information**. The parties acknowledge that each party may be exposed to or acquire communication or data of the other party that is confidential, privileged communication not intended to be disclosed to third parties. The provisions of this Section survive the termination of this Contract.

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

b. Obligation of Confidentiality. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or subcontractors 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 subcontractors of their obligations to keep all Confidential Information confidential. Disclosure to a subcontractor is permissible where: (a) use of a

subcontractor is authorized under this Contract; (b) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the subcontractor's responsibilities; and (c) Contractor obligates the subcontractor in a written contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor or any subcontractor may be required to execute a separate agreement to be bound by the provisions of this Section.

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

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

e. Surrender of Confidential Information upon Termination. Upon termination of this Contract or a Statement of Work, in whole or in part, each party must, within 5 calendar days from the date of termination, return to the other party any and all Confidential Information received from the other party, or created or received by a party on behalf of the other party, which are in such party's possession, custody, or control; provided, however, that Contractor must return State Data to the State following the timeframe and procedure described further in this Contract. Should Contractor 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 5 calendar days from the date of termination to the other party.

24. **Data Privacy and Information Security**.

a. Undertaking by Contractor. Without limiting Contractor's obligation of confidentiality as further described, Contractor is responsible for establishing and maintaining a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (a) ensure the security and confidentiality of the State Data; (b) protect against any anticipated threats or hazards to the security or integrity of the State Data; (c) protect against unauthorized disclosure, access to, or use of the State Data; (d) ensure the proper disposal of State Data; and (e) ensure that all employees, agents, and subcontractors of Contractor, if any, comply with all of the foregoing. In no case will the safeguards of Contractor's data privacy and information security program be less stringent than the safeguards used by the State, and Contractor must at all times comply with all applicable State IT policies and standards, which are available to Contractor upon request.

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

c. Right of Audit by the State. Without limiting any other audit rights of the State, the State has the right to review Contractor'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 Contractor's data privacy

and information security program. In lieu of an on-site audit, upon request by the State, Contractor agrees to complete, within 45 calendar days of receipt, an audit questionnaire provided by the State regarding Contractor's data privacy and information security program.

d. Audit Findings. Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

e. State's Right to Termination for Deficiencies. The State reserves the right, at its sole election, to immediately terminate this Contract or a Statement of Work without limitation and without liability if the State determines that Contractor fails or has failed to meet its obligations under this Section.

25. **Records Maintenance, Inspection, Examination, and Audit.** The State or its designee may audit Contractor to verify compliance with this Contract. Contractor must retain, and provide to the State or its designee and the auditor general upon request, all financial and accounting records related to the Contract through the term of the Contract and for 4 years after the latter of termination, expiration, or final payment under this Contract or any extension ("**Audit Period**"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

Within 10 calendar days of providing notice, the State and its authorized representatives or designees have the right to enter and inspect Contractor's premises or any other places where Contract Activities are being performed, and examine, copy, and audit all records related to this Contract. Contractor must cooperate and provide reasonable assistance. If any financial errors are revealed, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded. Any remaining balance at the end of the Contract must be paid or refunded within 45 calendar days.

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

26. **Warranties and Representations.** Contractor represents and warrants: (a) Contractor is the owner or licensee of any Contract Activities that it licenses, sells, or develops and Contractor has the rights necessary to convey title, ownership rights, or licensed use; (b) all Contract Activities are delivered free from any security interest, lien, or encumbrance and will continue in that respect; (c) the Contract Activities will not infringe the patent, trademark, copyright, trade secret, or other proprietary rights of any third party; (d) Contractor must assign or otherwise transfer to the State or its designee any manufacturer's warranty for the Contract Activities; (e) the Contract Activities are merchantable and fit for the specific purposes identified in the Contract; (f) the Contract signatory has the authority to enter into this Contract; (g) all information furnished by Contractor in connection with the Contract fairly and accurately represents Contractor's business, properties, finances, and operations as of the dates covered by the information, and Contractor will inform the State of any material adverse changes; and (h) all information furnished and representations made in connection with the award of this Contract is true, accurate, and complete, and contains no false statements or omits any fact that would make the information misleading. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 15 Termination for Cause.

27. **Conflicts and Ethics.** Contractor will uphold high ethical standards and is prohibited from: (a) holding or acquiring an interest that would conflict with this Contract; (b) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract; (c) attempting to influence or appearing to influence any State employee by the direct or indirect offer of anything of value; or (d) paying or agreeing to pay any person, other than employees and consultants working for Contractor, any consideration contingent upon the award of the Contract. Contractor must immediately notify the State of any violation or potential violation of these standards. This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

28. **Compliance with Laws.** Contractor must comply with all federal, state and local laws, rules and regulations.

29. **Nondiscrimination.** Under the 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*., Contractor and its subcontractors agree not to discriminate against an employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex, height, weight, marital status, or mental or physical disability. Breach of this covenant is a material breach of this Contract.

30. **Unfair Labor Practice.** Under MCL 423.324, the State may void any Contract with a Contractor or subcontractor who appears on the Unfair Labor Practice register compiled under MCL 423.322.

31. **Governing Law.** This Contract is governed, construed, and enforced in accordance with Michigan law, excluding choice-of-law principles, and all claims relating to or arising out of this Contract are governed by Michigan law, excluding choice-of-law principles. Any dispute arising from this Contract must be resolved in Michigan Court of Claims. Contractor consents to venue in Ingham County, and waives any objections, such as lack of personal jurisdiction or *forum non conveniens*. Contractor must appoint agents in Michigan to receive service of process.

32. **Non-Exclusivity.** Nothing contained in this Contract is intended nor will be construed as creating any requirements contract with Contractor. This Contract does not restrict the State or its agencies from acquiring similar, equal, or like Contract Activities from other sources.

33. **Force Majeure.** Neither party will be in breach of this Contract because of any failure arising from any disaster or acts of god that are beyond their control and without their fault or negligence. Each party will use commercially reasonable efforts to resume performance. Contractor will not be relieved of a breach or delay caused by its subcontractors. If immediate performance is necessary to ensure public health and safety, the State may immediately contract with a third party.

34. **Dispute Resolution.** The parties will endeavor to resolve any Contract dispute in accordance with this provision. The dispute will be referred to the parties' respective Contract Administrators or Program Managers. Such referral must include a description of the issues and all supporting documentation. The parties must submit the dispute to a senior executive if unable to resolve the dispute within 15 business days. The parties will continue performing while a dispute is being resolved, unless the dispute precludes performance. A dispute involving payment does not preclude performance.

    Litigation to resolve the dispute will not be instituted until after the dispute has been elevated to the parties' senior executive and either concludes that resolution is unlikely, or fails to respond within 15 business days. The parties are not prohibited from instituting formal proceedings: (a) to avoid the expiration of statute of limitations period; (b) to preserve a superior position with respect to creditors; or (c) where a party makes a determination that a temporary restraining order or other injunctive relief is the only adequate remedy. This Section does not limit the State's right to terminate the Contract.

35. **Media Releases.** News releases (including promotional literature and commercial advertisements) pertaining to the Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions of the State.

36. **Website Incorporation.** The State is not bound by any content on Contractor's website unless expressly incorporated directly into this Contract.

37. **Order of Precedence.** In the event of a conflict between the terms and conditions of the Contract, the exhibits, a purchase order, or an amendment, the order of precedence is: (a) the purchase order; (b) the amendment; (c) Exhibit A; (d) any other exhibits; and (e) the Contract.

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

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

40. **Survival.** The provisions of this Contract that impose continuing obligations, including warranties and representations, termination, transition, insurance coverage, indemnification, and confidentiality, will survive the expiration or termination of this Contract.

41. **Entire Contract and Modification.** This Contract is the entire agreement and replaces all previous agreements between the parties for the Contract Activities. This Contract may not be amended except by signed agreement between the parties (a "**Contract Change Notice**").

STATE OF MICHIGAN
Contract No. 071B6600031
Comprehensive Health Care Program for the
Michigan Department of Health and Human Services

EXHIBIT A
STATEMENT OF WORK
CONTRACT ACTIVITIES

This exhibit identifies the anticipated requirements of the Contract. The term "Contractor" in this document refers to UnitedHealthcare Community Plan.

Project Request
This is a Contract to obtain the services of one or more Contractors to provide Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan, as described herein.

This is a unit price-per member per month (PMPM) capitated rate Contract. Medicaid beneficiaries must have a choice among Contractors. Therefore, the State cannot guarantee a specific number of Enrollees to any Contractor. The Contractor must employ a population health management approach in all programs and interventions delivered to Medicaid beneficiaries.

Definitions
Contract definitions are provided at the end of Exhibit A.

Background
The Michigan Department of Health and Human Services (MDHHS) will employ a population health management framework and contract with high-performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves beneficiary experience and lowers cost. Through evidence- and value-based care delivery models, supported by health information technology/health information exchange and a robust quality strategy, MDHHS will support Contractors in achieving these goals.

Contractors must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. This includes the management of high-utilizers. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities.

MDHHS will support Contractors to implement payment reform initiatives that pay providers for value rather than volume; value defined as health outcome per dollar of cost expended over the full cycle of care. In this regard performance metrics will be linked to outcomes. Paying for value in the Medicaid population will move away from fee-for-service (FFS) models and embrace accountable and transparent payment structures that reward and penalize based on defined metrics.

Contractors must fully participate with MDHHS-directed payment reform initiatives implemented throughout the term of the Contract including, but not limited to, episodic payment, participation with Accountable Systems of Care including partial and global capitation, and the expansion of patient-centered medical homes. Contractors must fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, are served by person-centered models across all health care domains. Contractors are encouraged to propose and pilot innovative projects.

1.0 Specifications

1.1 Contractor Requirements

Contractor must provide deliverables and staff, and otherwise do all things necessary for or incidental to the requirements and performance of work, pursuant to the requirements set forth in this Contract. Contractor must comply with all provisions of Medicaid Policy applicable to Contractors unless provisions of this Contract stipulate otherwise. All policies, procedures, operational plans, and clinical guidelines followed by the Contractor must be in writing and available to MDHHS and Centers for Medicare and Medicaid Services (CMS) upon request. All medical records, report formats, information systems, liability policies, provider network information and other detail specific to performing the contracted services must be available to MDHHS and CMS upon request.

I. Service Area

A. Regional Service Areas

Contractors must operate in one or more of 10 regions throughout the State for the provision of covered services. Regions consist of entire counties. Contractors must provide evidence of network adequacy to MDHHS upon request. Regions are as follows:

1. Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft
2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon
4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newago, Oceana, Osceola, Ottawa
5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
7. Clinton, Eaton, Ingham
8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
10. Macomb, Oakland, Wayne

B. Service Area Expansion during Contract Term

Expansion of Contractors' service area(s) will be at the sole discretion of MDHHS.

C. Contiguous County Service Areas

Contractor may provide services in their contracted service areas through the use of provider networks in contiguous counties outside their contracted service area, subject to MDHHS approval. Contractor must provide a complete description of the provider network, including the identification of the contiguous counties with an available provider network and the counties in the region to be served through this provider network.

D. Rural Area Exception

The exception for rural area residents (42 CFR 438.52(b)(1)) that a choice of at least two managed care entities be available for beneficiaries mandatorily enrolled in managed care is currently in effect in Region 1, the 15-counties region that comprises Michigan's Upper Peninsula.

1. Medicaid beneficiaries who reside in Region 1 are mandatorily enrolled with a single Contractor permitted;
    a. Enrollees have a choice between at least two primary care providers.
    b. Enrollees have the option of obtaining services from any other network or non-network provider if the following conditions exist:
        i. The covered service, practitioner, or specialist is not available within the Contractor's network.
        ii. The provider is not part of the network but is the main source of a service to the Enrollee.

iii. The only provider available to the Enrollee does not, because of moral or religious objections, provide the service the Enrollee seeks.
iv. Related services must be performed by the same provider and all of the services are not available within the network.
v. MDHHS determines other circumstances that warrant out-of-network treatment.

2. MDHHS may implement a rural area exception policy in other regions during the course of this contract if necessary to accommodate enrollment, Contractors leaving the service area, or other factors.
3. Michigan counties for which the State has federal approval to implement a rural area exception policy are listed in Appendix 1 of this Contract.

II. Medicaid Eligibility and CHCP Enrollment Groups

A. Medicaid Eligibility

The Medical Services Administration administers the Medicaid program in Michigan. Eligibility is determined by the State with the sole authority to determine whether individuals or families meet eligibility requirements as specified for enrollment in the CHCP and other State assistance programs.

B. Children's Special Health Care Services (CSHCS) Eligibility

Eligibility for CSHCS (authorized by Title V of the Social Security Act) is determined by the State with the sole authority to determine whether individuals meet eligibility requirements. Individuals eligible for both CSHCS and Medicaid are a mandatorily enrolled Medicaid Eligible Group (See II-C (1)(c)).

1. Contractor must follow MDHHS procedures and provide any necessary information for the determination and redetermination of CSHCS eligibility.
2. Contractor or admitting hospital must submit a completed Medical Eligibility Referral Form (MERF) to MDHHS within 30 calendar days of hospital admission or Contractor's receipt of notification of the eligible condition for MDHHS to determine medical eligibility:
   a. When complete medical documentation meeting the guidelines specified by MDHHS is not available within the 30-days timeframe, the Contractor must submit the MERF and all required medical documentation within 10 calendar days after the information becomes available.
   b. Contractor must notify the Enrollee in a timely manner when submitting the MERF to MDHHS.
   c. Contractor must utilize the MDHHS procedures for MERF submission if there is any indication additional CSHCS-qualifying diagnoses maybe present.

C. Medicaid Eligible Groups

Within the Medicaid eligible population, there are groups enrolled in the CHCP mandatorily, groups who may voluntarily enroll, and groups excluded from enrollment. Those groups are as follows:

1. Medicaid Eligible Groups Mandatorily Enrolled in the CHCP:
   a. Children in foster care
   b. Families with children receiving assistance under the Financial Independence Program (FIP)
   c. Persons enrolled in Children's Special Health Care Services (CSHCS)
   d. Persons under age 21 who are receiving Medicaid
   e. Person Enrolled in the MIChild Program
   f. Persons receiving Medicaid for the aged
   g. Persons receiving Medicaid for the blind or disabled
   h. Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP

i. Pregnant women
j. Medicaid eligible persons enrolled under the Healthy Michigan Plan
k. Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare

2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
   a. Migrants
   b. Native Americans
   c. Persons with both Medicare and Medicaid eligibility
3. Medicaid Eligible Groups Excluded From Enrollment in the CHCP:
   a. Children in Child Care Institutions
   b. Deductible clients (also known as Spenddown)
   c. Persons without full Medicaid coverage
   d. Persons with Medicaid who reside in an Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or a State psychiatric hospital
   e. Persons receiving long-term care (custodial care) in a nursing facility
   f. Persons authorized to receive private duty nursing services
   g. Persons being served under the Home & Community Based Elderly Waiver
   h. Persons with commercial HMO/PPO coverage
   i. Persons in PACE (Program for All-inclusive Care for the Elderly)
   j. Persons in the Refugee Assistance Program
   k. Persons in the Repatriate Assistance Program
   l. Persons in the Traumatic Brain Injury program
   m. Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula
   n. Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
   o. Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan
   p. Persons incarcerated in a city, county, State, or federal correctional facility
   q. Persons participating in the *MI Health Link* Demonstration

III. Payment Reform

A. Value-Based Payment Models
1. Consistent with MDHHS's policy to move reimbursement from FFS to value-based payment models, Contractor agrees to increase the total percentage of health care services reimbursed under value-based contracts over the term of the agreement.
2. Contractor recognizes value-based payment models as those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Value-based payment models include, but are not limited to:
   a. Total capitation models
   b. Limited capitation models
   c. Bundled payments
   d. Supplemental payments to build practice-based infrastructure and Enrollee management capabilities
   e. Payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable

B. Patient-Centered Medical Homes
1. Contractor recognizes the need to support a robust primary care sector based on a patient-centered medical home (PCMH) model to ensure patient care is

managed across a continuum of care and specialty services will be accessed as appropriate.

2. Contractor recognizes that effective implementation of a patient-centered medical home model can result in savings to Contractor and used to further expand PCMH adoption by primary care clinicians.
3. Consistent with the MDHHS policy to support primary care providers, Contractor agrees to develop its own initiative to promote PCMH adoption among Michigan primary care providers, and to coordinate with practice-based and Michigan Primary Care Transformation (MiPCT) care managers for Enrollees.

C. Behavioral Health Integration

1. Contractor recognizes the importance of integrating both physical health and behavioral health services in order to effectively address Enrollee needs and improve health status.
2. Contractor agrees to work with MDHHS to develop initiatives to better integrate services covered by Contractor and the PIHP(s) serving Contractor's Enrollees and to provide incentives to support behavioral health integration.
3. Contractor agrees to collaborate with PIHPs and MDHHS to develop shared metrics to measure the quality of care provided to Enrollees jointly served by the Contractor and PIHPs.

D. Data Reporting

1. In order to continually improve the performance of its contracted providers, Contractor must collect and report data in a consistent and coordinated manner in collaboration with MDHHS.
2. Contractor agrees to work collaboratively with MDHHS and with other Contractors to develop standard measure specifications, data collection processes, baseline data, and reports that will be provided to contracted providers and MDHHS.

IV. CHCP Enrollment and Disenrollment

A. Enrollment Discrimination Prohibited

1. Contractor must not discriminate against individuals eligible to enroll on the basis of:
   a. Health status or the need for health services
   b. Race, color, or national origin and will not use any policy or practice that has the effect of discriminating as such
2. Contractor must accept Enrollees for enrollment in the order in which they apply without restriction.

B. Enrollment Services Contractor

MDHHS contracts with an enrollment services contractor to contact and educate Medicaid beneficiaries regarding managed care and assist beneficiaries to enroll, disenroll, and change enrollment with their Contractor. Because MDHHS holds the contract with the enrollment services contractor, this contract may reference MDHHS and by extension the enrollment services contractor may actually perform the service. Contractors must work with the enrollment services contractor as directed by MDHHS.

C. Initial Enrollment and Automatic Reenrollment

1. Contractor must accept as enrolled all beneficiaries listed on monthly HIPAA-compliant enrollment files/reports and infants enrolled by virtue of the mother's enrollment status (see IV-D (1)).
2. Enrollees disenrolled from the Contractor due to loss of Medicaid eligibility or other action will be prospectively reenrolled to the same Contractor automatically, provided eligibility is regained within two months.

D. Newborn Enrollment

1. Newborns will be automatically enrolled with the mother's Contractor at the time of birth.
2. Contractors will receive a full capitation payment for the month of birth.

3. Contractors must reconcile their birth records with the enrollment information supplied by MDHHS.
4. Contactors must submit a newborn service request to MDHHS no later than six months following the month for which the Contractor has a record of birth if:
    a. MDDHS has not notified the Contractor of an Enrollee birth for two months or more following the month for which the Contractor has a record of birth.
    b. The child is born outside Michigan.

E. Auto-assignment of Beneficiaries

1. Beneficiaries who do NOT select a health plan within the allotted time period will be automatically assigned to a Contractor based on the Contractor's capacity to accept new Enrollees and performance in areas specified by MDHHS (e.g., quality metrics).
2. MDHHS will automatically assign a larger proportion of beneficiaries to the highest performing Contractors. Members of a family unit will be assigned together whenever possible.
3. MDHHS has the sole authority for determining the methodology and criteria used for auto-assignment of beneficiaries.

F. Enrollment Lock-In and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions

Except as stated in this subsection, enrollment with the Contractor will be for a period of 12 months with the following conditions:

1. Sixty days prior to each Enrollee's annual open enrollment period, MDHHS will notify Enrollees of their right to disenroll with their current Contractor and reenroll with another Contractor.
2. Enrollees will be provided with an opportunity to select any Contractor approved for their county of residence during the annual open enrollment period.
3. Enrollees will be notified that inaction during open enrollment will retain their current Contractor enrollment.
4. Enrollees who choose to remain with the same Contractor will be deemed to have had their opportunity for disenrollment without cause and declined that opportunity until the next open enrollment period.
5. New Enrollees or Enrollees who change from one Contractor to another will have 90 days from the enrollment begin date with the Contractor to change Contractors without cause.
6. All enrollment changes will be approved and implemented by MDHHS, effective the next available calendar month.

G. Enrollment Effective Date

1. Contractor must provide covered services and coordination for services to Enrollees until their date of disenrollment. Changes in enrollment will be approved and implemented by MDHHS on a calendar month basis unless the Contractor is notified of a mid-month disenrollment on the daily enrollment file.
2. When an individual is determined eligible he or she is eligible for that entire month. Enrollees may be determined eligible retroactively.
3. With the exception of newborns, when an individual is determined to be Medicaid eligible, enrollment with a Contractor will occur on the first day of the next available month following the eligibility determination and enrollment process. Only full-month capitation payments will be made to the Contractor.
4. With the exception of newborns, the Contractor will not be responsible for paying for health care services during a period of retroactive eligibility prior to the date of enrollment with the Contractor.
5. If the beneficiary is in <u>any</u> inpatient hospital setting on the date of enrollment (first day of the month) Contractor will not be responsible for the inpatient stay or any

charges incurred prior to the date of discharge. Contractor must be responsible for all care from the date of discharge forward.

6. If an Enrollee is disenrolled from a Contractor and is in any inpatient hospital setting on the date of disenrollment (last day of the month) the Contractor must be responsible for all charges incurred through the date of discharge.
7. If an Enrollee becomes eligible for CSHCS, the effective date of enrollment in the CSHCS benefit plan is:
    a. The first of the month of the child's admission to a facility during which the eligible condition was identified by a pediatric subspecialist, or
    b. If the child was not admitted to a facility when the eligible condition was identified, the first of the month that eligible condition was identified by a pediatric subspecialist and services for the condition were provided.

H. Enrollment Errors by MDHHS

1. If a non-eligible individual or a Medicaid beneficiary who resides outside the Contractor's service area is enrolled with the Contractor and MDHHS is notified within 15 days of enrollment effective date, MDHHS must retroactively disenroll the individual and recoup the capitation payment from the Contractor. Contractor may recoup payments from its providers as allowed by Medicaid Policy and Contractor's provider contracts.
2. If a non-eligible individual is enrolled with a Contractor, and MDHHS is notified after 15 days of enrollment effective date, MDHHS will disenroll the Enrollee prospectively the first day of the next available month.

I. Disenrollment Discrimination Prohibited

1. Disenrollment provisions apply to all Enrollees equally, regardless of whether enrollment was mandatory or voluntary.
2. Contractors may not request disenrollment because of an Enrollee's
    a. Change in physical or mental health status
    b. Utilization of medical services

J. Special Disenrollments

1. Contractor may initiate special disenrollment requests to MDHHS if the Enrollee acts in a violent or threatening manner. Violent/threatening situations involve physical acts of violence; physical or verbal threats of violence made against Contracted providers, staff, or the public at Contractor locations or stalking situations.
2. Contractor must make contact with law enforcement, especially in cases of imminent danger, when appropriate, and refer the Enrollee to behavioral health providers when appropriate, before seeking disenrollment of Enrollees who exhibit violent or threatening behavior. MDHHS reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment.
3. When disenrollment is warranted, the effective disenrollment date must be within 60 days from the date MDHHS received the complete request from the Contractor that contains all information necessary for MDHHS to render a decision. If the beneficiary exercises their right of appeal, the effective disenrollment date must be no later than 30 days following resolution of the appeal.
4. MDHHS may consider reenrollment of beneficiaries disenrolled in these situations on a case-by-case basis.

K. Enrollees Who Move Out of the Contractor's Service Area

1. Contractor must provide all covered services to an Enrollee who moved out of the Contractor's service area after the effective date of enrollment, until the Enrollee is disenrolled from the Contractor. Contractor may require Enrollees to use network providers and provide transportation and/or authorize out-of-network providers to provide medically necessary services. Contractor may use its utilization

management protocols for hospital admissions and specialty referrals for Enrollees in this situation.

2. Contractor will receive a capitation payment for these Enrollees at the approved statewide average rate until disenrollment.
3. When requesting disenrollment, Contractor must submit verifiable information an Enrollee has moved out of the service area. MDHHS will expedite prospective disenrollments of Enrollees and process all such disenrollments effective the next available month after confirmation the Enrollee no longer resides in the Contractor's service area.
    a. If the Enrollee's street address on the enrollment file is outside of the Contractor's service area but the county code does not reflect the new address, the Contractor is responsible for requesting disenrollment within 15 days of the enrollment effective date.
    b. If the county code on the enrollment file is outside of the Contractor's service area, MDHHS will automatically disenroll the Enrollee for the next available month.

L. Long-Term Care

1. Contractor may initiate a disenrollment request if the Enrollee is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than 45 days. This provision applies equally to Medicaid and Healthy Michigan Plan Enrollees.
2. Contractor must provide MDHHS with medical documentation to support the disenrollment request in a timely manner using the format specified by MDHHS.
3. Contractor must cover all services for Enrollees until the date of disenrollment.
4. MDHHS may require additional information from the Contractor to assess the need for Enrollee disenrollment.

M. Administrative Disenrollments

1. Contractor may initiate disenrollment requests if an Enrollee's circumstances change such that the Enrollee no longer meets the criteria for enrollment with the Contractor as defined by MDHHS. Contractor must request disenrollment within 15 days of identifying the administrative circumstance.
2. Beneficiaries enrolled in the Healthy Michigan Plan later found to have Medicare eligibility will be retroactively disenrolled by MDHHS. Contractors are not required to submit a disenrollment request.

N. Disenrollment Requests Initiated by the Enrollee

1. Enrollees may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician who does not participate with the Contractor at the time of enrollment. The Enrollee must submit a medical exception request to MDHHS.
2. The Enrollee may request a "disenrollment for cause" from current Contractor at any time during the enrollment period that would allow the Enrollee to enroll with another Contractor. Reasons cited in a request for disenrollment for cause may include:
    a. Enrollee's current Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks and the Enrollee needs related services (e.g. a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.
    b. Lack of access to providers or necessary specialty services covered under the Contract. An Enrollee must demonstrate that appropriate care is not available within the Contractor's provider network or through non-network providers approved by the Contractor.

c. Concerns with quality of care.

3. Enrollee may request disenrollment from the Contractor if the open enrollment period was not available due to a temporary loss of Medicaid eligibility. If the Enrollee is mandatorily enrolled and resides in a county with two available MHPs, the Enrollee must choose another MHP in which to enroll; the Enrollee may not return to FFS Medicaid.

V. Access and Availability of Providers and Services

A. Network Requirements

1. Contractor must maintain a network of qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service area, including counties contiguous to Contractor's service area, for the provision of all covered services.
2. Contractor's provider network must be sufficient to serve the maximum number of Enrollees specified under this Contract including CSHCS Enrollees and persons with special health care needs and submit documentation to MDHHS to that effect.
3. Contractor must ensure contracted PCPs have a system to provide or arrange for coverage of services 24 hours per day, 7 days per week when medically necessary.
4. Contractor must consider anticipated enrollment and expected utilization of services with respect to the specific Medicaid populations (e.g., disabled, CSHCS, duals).
5. Contractor must ensure Enrollees have an ongoing source of primary care appropriate to the Enrollees needs and covered services are administered or arranged for by a formally designated PCP.
6. Contractor must ensure contracted providers offer an appropriate range of preventive care, primary care, and specialty services to meet the needs of all Enrollees including CSHCS Enrollees and persons with special health care needs and submit documentation to MDHHS to that effect.
7. Contractor must maintain a PCP-to-Enrollee ratio of at least one full-time (minimum of 20 hours per week per practice location) PCP per 750 members, except when this standard cannot be met because a geographic area (rural county) does not have sufficient PCPs to meet this standard; MDHHS has the sole authority to determine whether an exception will be granted.
8. Contractor must provide access to specialists, including specialists in contiguous counties to the Contractor's service area, if those specialists are more accessible or appropriate for the Enrollee.
9. Contractor must maintain a network of pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers to provide care for CSHCS Enrollees.
10. Contractor must consider the geographic location of providers and Enrollees, including distance, travel time and available means of transportation and whether the provider location provides access for Enrollees with physical or developmental disabilities.
11. Contractor must ensure PCP services, and hospital services are available within 30 miles or 30 minutes travel time from the Enrollee's home unless MDHHS grants an exception.
12. Contractor must consider, and participate with MDHHS initiatives (e.g. HHS CLAS), to promote the delivery of services in a culturally responsive manner to all Enrollees including those with limited proficiency in English, deaf and hard of hearing (DHOH), and diverse cultural and ethnic backgrounds.
13. Contractor must provide for a second opinion from a qualified health care professional within the network or arrange for the Enrollee to obtain one out of network at no cost to the Enrollee.

14. Contractor must arrange for laboratory services through laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.
15. Contractor must ensure female Enrollees are provided access to a women's health specialist for women's necessary preventive and routine health care services in addition to the Enrollee's designated PCP if that provider is not a women's health specialist.

B. Changes in Provider Network

1. Contractor must notify MDHHS within seven days of any changes to the composition of the Contractor's provider network that may affect the Contractor's ability to make available all covered services in a timely manner.
2. Contractor must have written procedures to address network changes that negatively affect Enrollees' access to care; MDHHS may apply sanctions to the Contractor if a network change that negatively affects Enrollees' access to care is not reported timely, or the Contractor is not willing or able to correct the issue.
3. Contractor must submit documentation attesting to network adequacy if:
    a. There are changes in services, benefits, service area, or payments
    b. A new population is enrolled

C. Access to Care

1. Contractor must ensure Enrollees have access to emergency and urgent care services 24 hours per day, 7 days per week. All PCPs within the network must have information on this system and reinforce with their Enrollees the appropriate use of the health care delivery system.
2. Contractor must require that physician office visits be available during regular and scheduled office hours.
    a. Contractor must ensure that Enrollees have access to evening and weekend hours of operation in addition to scheduled daytime hours.
    b. Contractor must provide notice to Enrollees of the hours and locations of service for their assigned PCP network providers' office hours.
3. Contractor must make available direct contact with a qualified clinical staff person through a toll-free telephone number at all times, 24 hours per day, 7 days per week.
4. Contractor must maintain MDHHS-approved standards for, monitor, and report to MDHHS.
    a. The amount of time between scheduling an appointment and the date of the office visit including routine appointments, urgent appointments and emergent appointments.
    b. The length of time Enrollees spend waiting in the provider office.

D. Out of Network Providers

1. Contractor must provide timely access to out of network providers and cover medically necessary services for Enrollees if the Contractor's network is unable to provide those services.
2. Contractor must coordinate with out of network providers with respect to payment and follow all applicable MDHHS policies to ensure the Enrollee is not liable for costs greater than would be expected for in network services including a prohibition on balance billing (XIV-F(6)); Medicaid Provider Manual).

E. Primary Care Provider (PCP) Selection

The PCP is responsible for supervising, coordinating, and providing primary care, initiating referrals for specialty care, maintaining continuity of each Enrollee's health care, and maintaining the Enrollee's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services for each assigned Enrollee.

1. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician, nurse practitioners, physician assistants, and other physician specialists when appropriate for an Enrollee's health condition.

a. Contractor must allow a physician specialist to serve as a PCP when the Enrollee's medical condition warrants management by a physician specialist (e.g., end-stage renal disease, HIV/AIDS, other chronic disease or disability). Management by a physician specialist will be determined on a case-by-case basis in consultation with the Enrollee.
b. Contractors must ensure specialists as PCPs can adequately provide all necessary primary care services prior to assigning a specialist as PCP. If the Enrollee disagrees with the Contractor's decision, the Enrollee should be informed of his or her grievance and appeal rights (XIII-G).

2. Contractor must provide all Enrollees the opportunity to select their PCP at the time of enrollment.
   a. When an Enrollee chooses a PCP, Contractor must assign the Enrollee to the PCP of his or her choice as indicated on the proprietary daily enrollment file from the enrollment services contractor (4276).
   b. Enrollee may choose a clinic as their PCP provided that the provider files submitted to MDHHS's enrollment services contractor is completed consistent with MDHHS requirements and the clinic has been approved by MDHHS to serve as a PCP.
   c. Contractor must allow CSHCS Enrollees to remain with their established PCP at the time of enrollment with the Contractor not limited to in network providers; upon consultation with the family and care team, CSHCS enrollees may be transitioned to an in-network PCP.
3. When the Enrollee does not choose a PCP at the time of enrollment, the Contractor must assign a PCP no later than 30 days after the effective date of enrollment.
   a. The assigned PCP must be within 30 miles or 30 minutes travel time to the Enrollee's home with the following exceptions.
      i. The Enrollee is CSHCS-eligible and a PCP over 30 miles or 30 minutes travel time to the Enrollee's home is the most appropriate for the Enrollee.
      ii. Contractor is able to document that no other network provider is accessible within 30 miles or 30 minutes travel to the Enrollee's home.
   b. CSHCS Enrollees who do not choose a PCP must be assigned a CSHCS-attested PCP (see V-F).
   c. Contractor must take the availability of handicap accessible public transportation into consideration when making PCP assignments.
4. Contractor must allow a CSHCS Enrollee to choose a non-network PCP if:
   a. The CSHCS Enrollee has an established relationship with the PCP at the time of enrollment with the Contractor.
   b. Upon consultation with the family, the selected PCP is the most appropriate for the CSHCS Enrollee.
5. Contractor must have written policies and procedures describing how Enrollees choose a PCP, are assigned to a PCP, and how they may change their PCP.
   a. Contractors must provide Enrollees the opportunity to change their PCP regardless of whether the PCP was chosen by the Enrollee or assigned by the Contractor.
   b. Contractor must not place restrictions on the number of times an Enrollee can change PCPs with cause.
   c. Contractor may establish a policy that restricts the Enrollee's ability to change PCPs without cause; prior to implementing such a policy, Contractors must receive MDHHS approval.

6. Contractor must notify all Enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.

F. CSHCS PCP Requirements

1. Contractors must assign CSHCS Enrollees to CSHCS-attested PCP practices that provide family-centered care.
2. Contractors must obtain a written attestation from PCPs willing to serve CSHCS Enrollees that specifies the PCP/practice meets the following qualifications:
    a. Is willing to accept new CSHCS Enrollees with potentially complex health conditions.
    b. Regularly serves children or youth with complex chronic health conditions.
    c. Has a mechanism to identify children/youth with chronic health conditions.
    d. Provides expanded appointments when children have complex needs and require more time.
    e. Has experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
    f. Has a designated professional responsible for care coordination for children who see multiple professionals.
    g. Provides services appropriate for youth transitioning into adulthood.
3. Contractors must maintain a roster of providers who meet the criteria listed above and able to serve CSHCS Enrollees.

G. Family Planning Services

1. Contractor must ensure that Enrollees have full freedom of choice of family planning providers, both in-network and out-of-network.
    a. Contractor may encourage the use of public providers in their network.
    b. Contractor may encourage family planning providers to communicate with PCPs once any form of medical treatment is undertaken.
2. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization.
3. Regarding type, duration or frequency of drugs, supplies and devices for the purpose of family planning, Contractors may not be more restrictive than Medicaid FFS.
4. Contractor must pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service, at established Medicaid FFS rates in effect on the date of service.
5. Contractor must maintain accessibility and confidentiality for family planning services through promptness in scheduling appointments, particularly for minors.
6. Contractor must make certain Medicaid funding is not used for services for the treatment of infertility.

H. Pregnant Women

1. Contractor must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice.
2. Contractor must allow pregnant women to receive all medically necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in network provider.
3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate.

I. Maternity Care

1. Contractor must ensure an individual maternity care provider is designated for each enrolled pregnant woman for the duration of her pregnancy and post-partum care.
    a. Maternity care providers scope of practice must include maternity care and meet the Contractor's credentialing requirements.
    b. A clinic or practice may be designated as the maternity care provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care.
2. Contractor must allow an Enrollee's maternity care provider to also be the Enrollee's PCP if primary care is within their scope of practice.

J. Child and Adolescent Health Centers and Programs

1. Enrollees may choose to obtain covered services from a Child and Adolescent Health Centers and Programs (CAHCPs) provider without prior authorization from the Contractor. Contractors must pay Medicaid FFS rates in effect on the date of service, if the Contractor does not contract with the CAHCP.
2. Contractor may contract with a CAHCP to deliver covered services as part of the Contractor's network. If the CAHCP is in the Contractor's network, the following conditions apply:
    a. Covered services must be medically necessary and administered by or arranged by a designated PCP.
    b. The CAHCP will meet the Contractor's written credentialing and re-credentialing policies and procedures for ensuring quality of care and ensuring all providers rendering services to Enrollees are licensed by the State and operate within their scope of practice as defined for them in Michigan's Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211.
    c. Contractor must reimburse the CAHCP according to the provisions of the contractual agreement.

K. Out-of-Network Services

1. Contractor must authorize and reimburse out-of-network providers for medically necessary covered services if such services could not reasonably be obtained by a network provider on a timely basis inside or outside the State of Michigan.
2. Covered services are considered authorized if the Contractor does not respond to a request for authorization within 24 hours of the request (III. Services Covered Under this Contract (D)(9)). This provision applies to out-of-network providers inside and outside the State of Michigan.
3. Contractor must comply with all related Medicaid Policies regarding authorization and reimbursement for out-of-network providers.
    a. Contractor must pay out-of-network Medicaid providers' claims at established Medicaid fees in effect on the date of service.
    b. If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid Policy to determine the correct payment amount.

L. Federally Qualified Health Centers (FQHCs)

1. Contractor must provide Enrollees with access to services provided through an FQHC if the Enrollee resides in the county in which the FQHC is located and if the Enrollee requests such services. Contractor must inform Enrollees of this right in their member handbooks.
2. If a Contractor has an FQHC in its provider network in the county and allows Enrollees to receive medically necessary services, including behavioral/mental health services provided as part of the 20 outpatient mental health visits, from the

FQHC, the Contractor has fulfilled its responsibility to provide FQHC services and does not need to allow Enrollees to access FQHC services out-of-network.

3. If a Contractor does not include an FQHC in the provider network in the county and an FQHC exists in the county, the Contractor must allow Enrollees to receive services from the out-of-network FQHC.
4. FQHC services must be prior authorized by the Contractor; however, the Contractor may not refuse to authorize medically necessary services if the Contractor does not have an FQHC in the network for the service area (county).
5. The Social Security Act requires Contractors pay the FQHCs at least as much as the Contractor pays to a non-FQHC provider for the same service. Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs.
6. FQHCs are entitled, pursuant to the Social Security Act, to prospective payment reimbursement through annual reconciliation with MDHHS. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903(m) organizations (health plans) and the reasonable cost of FQHC subcontracts with the 1903(m) organization.

M. Indian Health Service/Tribally-Operated Facility/Program/Urban Indian Clinic (I/T/U)

1. If an Indian Health Facilities, I/T/U provider is contracted with the MHP, Native Americans who enrolled in the plan must be allowed to choose the I/T/U provider as their PCP. If the I/T/U is not contracted with the MHP, Native Americans must still be allowed to use the provider without authorization.
2. I/T/U providers are entitled, pursuant to the ARRA 5006, to be paid for covered Medicaid services at the same payment that would be made if the provider were a non-I/T/U participating provider.
3. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903(m) organizations (health plans) and the amount they would receive per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

N. Children's Multidisciplinary Specialty (CMDS) Clinics

1. Contractor must establish and maintain a coordination agreement with each CMDS clinic/facility to ensure coordinated care planning and data sharing, including but not limited to the assessment and treatment plan.
2. Contractor must utilize an electronic data system by which providers and other entities can send and receive client-level information for the purpose of care management and coordination (VIII.-C).
3. Contractor must cover transportation of Enrollees to CMDS clinics, if requested.
4. Contractor must reimburse for covered services provided at CMDS clinics.
5. MDHHS must cover any special facility fees charged by CMDS clinics.

O. Local Health Departments and CSHCS Coordination

1. Contractor must enter into an agreement with all Local Health Departments (LHDs) to coordinate care for CSHCS Enrollees in Contractor's service area; the agreement must address the following topics:
    a. Data sharing
    b. Communication on development of Care Coordination Plans
    c. Reporting requirements
    d. Quality assurance coordination
    e. Grievance and appeal resolution
    f. Dispute resolution and
    g. Care planning for Enrollees transitioning into adulthood

2. Contractor must utilize an electronic data system by which providers and other entities can send and receive client-level information for the purpose of care management and coordination (VIII-C).
3. Contractor must assess the need for a care manager and family-centered care plan, and if established, updated annually.
4. Contractor may share Enrollee information with Local Health Departments to facilitate coordination of care without specific agreements.

P. State Laboratory

1. Contractor must reimburse the State Laboratory (State Lab) for specific tests performed for the Contractor's Enrollees; specific tests for which reimbursement is required are listed in Appendix 11.
    a. Contractor must not require the State Lab to obtain prior authorization or contract with the Contractor for the purposes of providing the laboratory services listed in Appendix 11.
    b. In the absence of a contract or agreement at the time services are performed, the Contractor must make payment to the State Lab at established Medicaid FFS rates in effect on the date of service.
2. The State is responsible for ensuring the State Lab provides all beneficiary-level data related to the tests listed in Appendix 11 performed by the MDHHS Lab. For all tests performed, the State Lab must provide this data to the Contractor within 90 days of performing the test.

VI. Covered Services

A. General

1. Contractor must have available and provide, at a minimum, the appropriate medically necessary covered services defined as services related to one or more of the following:
    a. The prevention, diagnosis, and treatment of health impairments.
    b. The ability to achieve age-appropriate growth and development.
    c. The ability to attain, maintain, or regain functional capacity.
2. Contractor must conform to professionally accepted standards of care and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an Enrollee.
3. Contractor must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If new Medicaid services are added, expanded, eliminated, or otherwise changed, Contractor must implement the changes consistent with State direction and the terms of this Contract.
4. Contractor must ensure all reporting requirements, quality assurance, and compliance activities required by MDHHS of the Contractor apply equally to all subcontractors used for the provision of covered services.

B. Services Covered Under this Contract

1. Contractor must provide the full range of covered services listed below and any outreach necessary to facilitate Enrollees use of appropriate services. Contractors may choose to provide services over and above those specified. Covered services provided to Enrollees under this Contract include, but are not limited to, the following:
    a. Ambulance and other emergency medical transportation
    b. Breast pumps; personal use, double-electric
    c. Mental health services, maximum 20 outpatient visits per calendar year
    d. Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
    e. Certified nurse midwife services
    f. Certified pediatric and family nurse practitioner services
    g. Chiropractic services
    h. Diagnostic laboratory, x-ray and other imaging services

i. Durable medical equipment (DME) and supplies including those that may be supplied by a pharmacy
j. Emergency services
k. End Stage Renal Disease (ESRD) services
l. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
m. Health education
n. Hearing and speech services
o. Hearing aids for Enrollees under 21 years of age
p. Home Health services
q. Hospice services (if requested by the Enrollee)
r. Immunizations
s. Inpatient and outpatient hospital services
t. Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 days
u. Maternal and Infant Health Program (MIHP) services (effective Oct 1, 2016)
v. Medically necessary weight reduction services
w. Non-emergent medical transportation (NEMT) to medically-necessary, covered services
x. Out-of-state services authorized by the Contractor
y. Parenting and birthing classes
z. Pharmacy services
aa. Podiatry services
bb. Practitioners' services
cc. Preventive services required by the Patient Protection and Affordable Care Act as outline by MDHHS
dd. Prosthetics and orthotics
ee. Restorative or rehabilitative services in a place of service other than a nursing facility
ff. Sexually transmitted infections (STI) treatment
gg. Tobacco cessation treatment including pharmaceutical and behavioral support
hh. Therapies (speech, language, physical, occupational and therapies to support activities of daily living) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
ii. Transplant services
jj. Vision services
kk. Well-child/EPSDT for persons under age 21

2. Additional Services Covered for Healthy Michigan Plan Enrollees
The covered services provided to HMP Enrollees under this Contract include all those listed above and the following services:
a. Habilitative services
b. Dental services
c. Hearing aids for persons age 21 and over

C. Health Promotion and Education
1. Contractor must <u>not</u> charge an Enrollee a fee for participating in health promotion and education programs for covered services as delineated in section VI-B (1)(a-kk) above.
2. Contractor may charge a nominal fee if the Enrollee elects to participate in programs not primarily related to covered services.

D. Pharmacy Services

1. Contractors must provide pharmacy services to Enrollees according to Medicaid Policy and MDHHS-established protocol.
2. Contractors must operate a Drug Utilization Review (DUR) program through either a Pharmacy and Therapeutics committee or DUR board for the purpose of meeting coverage standards delineated under Section 1927 of the SSA..
3. Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug, vitamin or supplement that is covered under the Medicaid Pharmaceutical Product List (MPPL).
4. Drug coverages must include over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin, as covered by the Medicaid FFS program.
    a. Condoms must be made available to all eligible enrollees without a prescription; quantity limits for condoms must be no more restrictive than Medicaid FFS.
5. Contractor must provide family planning services in accordance with section ***V.G. Family Planning Services*** of this contract.
6. Contractor must provide tobacco cessation services in accordance with section ***VI.G Tobacco Cessation*** of this contract.
7. Contractor must collaborate with all MDHHS initiatives related to MCO Common Formulary, rebates and the delivery of services.
8. Outpatient pharmacy point-of-sale coding must be updated within sixty (60) days following MDHHS approval of a change to the MCO Common Formulary.
9. MDHHS must be provided access to the Contractor's published formulary to facilitate MCO Common Formulary compliance monitoring.
10. Compliance with the MCO Common Formulary will include but is not limited to:
    a. Coverage and utilization management tools (e.g. prior authorization, step therapy, quantity limits, and age or gender edits) may be less restrictive, but not more restrictive than the MCO Common Formulary.
    b. Contractor must follow the MCO Common Formulary procedures for transitions of care and grandfathering
    c. Contractor must establish a point-of-sale mechanism which instructs pharmacies to submit claims for FFS pharmacy carve-outs to the MDHHS vendor
11. Maximum Allowable Cost (MAC) and all other pharmacy pricing standards must be updated at least once every 7 days.
12. A process for MAC pricing reconsiderations must be developed to ensure compliance with MCL 400.109l.
13. Contractor is NOT responsible for drugs in the categories listed on the Medicaid Health Plan carve-out list found at https://michigan.fhsc.com/Providers/DrugInfo.asp;
    a. Contractor is responsible for covering lab and x-ray services related to the ordering of prescriptions on the carve-out list for enrollees, but may limit access to contracted lab and x-ray providers.
    b. These medications are reimbursed by the MDHHS pharmacy third party administrator (TPA) through the point-of-sale reimbursement system.
    c. Medications not billed at point-of-sale using the NCPDP format are the responsibility of the Contractor except as noted in the Provider Manual.

E. Emergency Services

1. Contractor must cover emergency services and medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USC 1395dd(a)). Enrollees must be screened and stabilized without prior authorization.
2. Contractor must ensure emergency services are available 24 hours per day and 7 days per week.

3. Contractor must be responsible for payment of all out-of-plan or out-of-area emergency services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services.
4. Contractor must cover emergency services regardless of whether the emergency department provider or hospital notified the Enrollee's primary care provider or Contractor of the Enrollee's services in the emergency department. Unless a representative of the Contractor instructed the Enrollee to seek emergency services, the Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.
5. Contractor must provide emergency transportation for Enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, the emergency transportation provider must submit a properly completed and coded claim form for emergency transport, which includes an appropriate diagnosis code as described in Medicaid Policy.
6. Contractor must provide professional services needed to evaluate or stabilize an emergency medical condition found to exist using a prudent layperson standard. Contractor acknowledges that hospitals offering emergency services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. Contractor further acknowledges that if an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Enrollee.
7. Contractor must ensure that emergency services continue until the Enrollee is stabilized and can be safely discharged or transferred.
8. Contractor must cover (consistent with § 422.214) post-stabilization care services obtained within or outside the Contractor's network that are pre-approved by a Contractor provider or other Contractor representative.
9. Contractor must cover post-stabilization care services, regardless of whether the services were provided in the Contractor's network, which are not pre-approved by a Contractor provider or other Contractor representative, but administered to maintain the Enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.
10. If an Enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services. Such services must be deemed prior authorized under any of the following conditions:
    a. If the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) to a request for authorization made by the emergency department.
    b. If the Contractor is not available when the request for post-stabilization services occurs.
    c. If the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria specified below is met.
11. Contractor's financial responsibility for post-stabilization care services not pre-approved ends when any of the following conditions are reached:
    a. Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care.

b. Contractor physician assumes responsibility for the Enrollee's care through transfer.
c. Contractor representative and the treating physician reach an agreement concerning the Enrollee's care.
d. The Enrollee is discharged.

F. Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit (42 USC Sec. 1396D(R)(5), 1396D(A)), also referred to as a well-child visit, is a federal mandate that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. States are required to provide comprehensive services including appropriate preventive, dental, behavioral health, and developmental, and specialty services needed to correct and ameliorate health conditions, based on federal guidelines. EPSDT provides for coverage of all medically necessary services included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act, regardless of whether such services are covered under the State Plan. Refer to ***EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014*** for more information on the administration of this benefit.

1. Contractors must ensure screenings and laboratory services are provided to Enrollees under 21 years of age according to the American Academy of Pediatrics ***Bright Futures*** Recommendations for Preventive Pediatric Health Care periodicity schedule (see Appendix 6).
2. Contractor must make appropriate referrals for diagnostic or treatment services determined necessary by the Enrollee's health care provider.
3. Contractor must provide the appropriate services to correct or ameliorate any conditions found during the screening process.
4. Contractor must provide outreach to Enrollees due or overdue for well-child/EPSDT visits, including phone, mail, home-visiting or other means of communication acceptable to the Enrollee; the Contractor may meet this requirement by contracting or collaborating with community-based organizations and providers.

G. Tobacco Cessation Treatment

1. Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.
2. Contractor must provide tobacco cessation treatment that includes, at a minimum, the following services:
   a. Intensive tobacco cessation treatment through an MDHHS-approved telephone quit-line.
   b. Individual tobacco cessation counseling/coaching (separate from the 20 outpatient mental health visits covered by the Contractor) in conjunction with tobacco cessation medication or without
   c. Non-nicotine prescription medications
   d. Prescription inhalers and nasal sprays
   e. The following over-the-counter agents
      i. Patch
      ii. Gum
      iii. Lozenge
   f. Combination therapy – the use of a combination of medications, including but not limited to the following combinations
      i. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
      ii. Nicotine patch and inhaler
      iii. Nicotine patch and bupropion SR

H. Transportation

1. Contractor must provide non-emergent medical transportation (NEMT), including travel expenses, to authorized, covered services.
2. Contractor must provide NEMT for CSHCS Enrollees with PCPs outside the 30 miles or minutes travel time from the Enrollee's home.
3. Contractor must submit to MDHHS policies and procedures for the coverage of NEMT, including travel expenses, updated at least annually.
    a. Contractor must submit equivalent policies and procedures for transportation subcontractors.
    b. Contractor must provide procedures and documentation for purposes of monitoring subcontractors to ensure compliance with these provisions.
4. Contractor/Subcontractor policies must include provisions for the following:
    a. Determination of the most appropriate mode of transportation to meet the Enrollee's medical needs, including special transport requirements for Enrollees who are medically fragile or Enrollees with physical/mental challenges, pregnancy status, infancy, need for Enrollee to keep appointments confidential (such as when it is not appropriate for Enrollees to ask neighbors or family members for transportation), additional riders and/or car seats, housing status that affects pick up and drop off locations
    b. Prevention of excessive multi-loading of vehicles such that Enrollees are not unduly burdened or forced to travel for significantly longer periods of time than is necessary
    c. Scheduling system must be able to schedule Enrollee transportation services in at least three modes:
        i. On-going prescheduled appointments for at least thirty days, such as, but not limited to, dialysis, chemotherapy or physical therapy
        ii. Regularly scheduled appointments; plans may require reasonable advance notice (e.g. 48 – 72 hours) of the need for transportation
        iii. Urgently scheduled appointments for which the Enrollee requires transportation on the same day as the request or the following day
        iv. Method for reimbursing mileage to individuals when it is appropriate for the Enrollee to drive or be driven to an urgent care facility or emergency department
5. Contractor may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles; prior authorization may not be denied based on distance alone.
6. Contractors must make appropriate accommodations for Enrollees with special transportation needs, including but not limited to, CSHCS Enrollees.
7. MDHHS will monitor transportation services provided by the Contractor including grievances and appeals.

I. Transplant Services

1. Contractor must cover all costs associated with transplant surgery and care; related care may include, but is not limited to, organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs.
2. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, small bowel, and bone marrow including allogenic, autologous and peripheral stem cell harvesting) must be covered on a patient-specific basis when determined medically necessary according to currently accepted standards of care.
3. Contractor must have a process in place to evaluate, document, and act upon such requests.

J. Communicable Disease Services
Contractor must allow Enrollees to receive treatment services for communicable diseases from local health departments without prior authorization; including HIV/AIDS, sexually-transmitted infections, tuberculosis, and vaccine-preventable communicable diseases.

K. Restorative/Rehabilitative Health Services
1. Contractor must provide restorative/rehabilitative health services or rehabilitative nursing care for Enrollees when medically necessary.
   a. Enrollees in a nursing facility may receive restorative/rehabilitative care for up to 45 days (within a rolling 12 month period from initial admission).
   b. The 45-day maximum stay does not apply to restorative/rehabilitative health services provided in places of service other than a nursing facility.
2. Contractor must coordinate care and supports services provided outside the contract, such as home help services.

L. Hospice Services
1. Contractor must provide all authorized and medically-necessary hospice services in accordance with Medicaid policy and medically-accepted standards of care, including “room and board” when provided in a nursing home or hospital.
2. Enrollees who have elected the hospice benefit will not be disenrolled after 45 days in a nursing home as otherwise permitted for long term care disenrollments.

M. Twenty Visit Mental Health Outpatient Benefit
1. Contractor must provide a maximum of 20 outpatient mental health visits per calendar year consistent with Medicaid Policy.
2. Contractor may provide services through contracts with Community Mental Health Services Programs (CMHSPs), Prepaid Inpatient Health Plans (PIHPs), or contracts with other appropriate network providers.

N. Maternal Infant Health Program *(Effective October 1, 2016)*
The Maternal and Infant Health Program (MIHP) is a home-visiting program for Medicaid-eligible women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP provider organizations must be certified by MDHHS and adhere to program policies, procedures, and expectations outlined in Medicaid Policy, the MIHP Program Operations Manual and Public Act 291 of 2012.
1. To administer this benefit, Contractor must establish and maintain agreements with MIHP provider organizations in the Contractor’s service area or operate their own MDHHS-certified MIHP.
2. Agreements between the Contractor and certified MIHP provider organizations must be made available to MDHHS upon request and address the following issues:
   a. Medical coordination, including pharmacy and laboratory coordination
   b. Data and reporting requirements
   c. Quality assurance coordination
   d. Grievance and appeal resolution
   e. Dispute resolution
   f. Transportation
   g. Enrollee assignment to an MIHP provider organization within 30 days of MIHP eligibility determination, if Enrollee is not already enrolled in another evidenced based home-visiting program
   h. Sufficient number of MIHP providers to meet Enrollee service and visitation needs within the required response time according to MDHHS MIHP protocols.
   i. Service delivery response times
3. Contractor must assign all MIHP-eligible Enrollees to an MIHP provider organization for MIHP outreach, screening and care coordination within one month of the effective date of MIHP eligibility determination if an Enrollee is not already enrolled in another evidenced based home visiting program.

a. MIHP services are voluntary. Enrollees must be provided an opportunity to select an MIHP provider organization. If Enrollee does not choose an MIHP provider organization at the time of MIHP eligibility determination, it is Contractor's responsibility to assign an MIHP provider organization within one month of the effective date of MIHP eligibility determination.

b. Contractor must provide Enrollees an opportunity to change their MIHP provider organization among those with which Contractor maintains agreements and to decline MIHP screening and services.

4. Contractor must present to MDHHS evidence of MIHP assignment and care coordination, or evidence of participation in another evidence based home visiting model, for all MIHP-eligible Enrollees upon request.

5. Contractor must hold regularly scheduled meetings, not less than quarterly, with each MIHP for the purpose of developing medical coordination processes, including data sharing, workflow to improve resource coordination, and new initiatives to address home-visiting Enrollee needs.

6. Contractor must report annually to MDHHS on the activities undertaken pursuant to this section, including providing a summary and templates of executed agreements, specific examples of collaborative approaches and program successes, and a summary quality improvement initiative will be undertaken and planned to enhance coordination of case management services.

7. If an Enrollee is currently receiving services from an MIHP provider at the time of enrollment with the Contractor and the Contractor does not have an agreement with that MIHP provider, the Contractor must pay the MIHP provider Medicaid FFS rates until case closure.

O. Vaccines and Immunizations

1. Contractor must provide Enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and in accordance with Medicaid Policy.
2. Contractor must participate in local and State immunization initiatives/programs.
3. Contractor must require contracted providers to participate with and submit Enrollee data to the Michigan Care Improvement Registry (MCIR). Contractors must offer training and educational materials to providers to facilitate this process.
4. Contractors must encourage eligible providers to register with the Vaccines for Children (VFC) program in order to obtain vaccines and immunizations at no cost and provide them to Enrollees younger than 19 years of age at no cost.
5. For Enrollees who receive vaccines and immunizations at local health departments (LHDs) Contractors must reimburse LHDs for all vaccines and immunizations and associated administration fees regardless of whether a contract exists between the Contractor and the LHD.

   a. If a contract does not exist, Contractors must reimburse LHDs for all vaccines and immunizations and associated administration fees at the Medicaid FFS rate in effect on the date of service.

   b. When an Enrollee receives a vaccine or immunization at an LHD participating in the VFC program, the Contractor must reimburse the LHD for the associated administration fee.

6. Contractors must not require prior authorization for any vaccines and immunizations provided to Enrollees at LHDs regardless of Enrollee age or whether the vaccine or immunization was provided as part of the VFC program.

VII. Coordination for Services Covered Outside this Contract

The Contractor must provide information to the Enrollee regarding the availability of these services and coordinate care as appropriate.

A. General

1. Dental services for all Enrollees (except HMP)
2. Services provided by a school district and billed through the Intermediate School District
3. Inpatient hospital psychiatric services (see Appendix 7)
4. Outpatient partial hospitalization psychiatric care
5. Intermittent or short-term restorative or rehabilitative services (in a nursing facility), after disenrollment
6. Mental health services in excess of 20 outpatient visits each calendar year
7. Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
8. Substance use disorder services through accredited providers including:
    a. Assessment
    b. Detoxification (see Appendix 8)
    c. Intensive outpatient counseling and other outpatient services
    d. Methadone treatment and other substance use disorder treatment
9. Services, including therapies (speech, language, physical, occupational), provided to persons with intellectual and/or developmental disabilities (I/DD) which are billed through Community Mental Health Services Program providers or Intermediate School Districts
10. Custodial care in a nursing facility
11. Home and Community-Based Waiver Program services
12. Personal care or home help services
13. Transportation for services provided to persons with developmental disabilities which are billed through CMHSP

B. Services Prohibited or Excluded under Medicaid

1. Contractor is prohibited from using State funds to provide the following services
    a. Elective cosmetic surgery
    b. Services for treatment of infertility
    c. Experimental/investigational drugs, biological agents, procedures devices, or equipment
    d. Elective abortions and related services
2. Abortions may be covered if one of the following conditions is met:
    a. A physician certifies that the abortion is medically necessary to save the life of the mother
    b. The pregnancy is a result of rape or incest
    c. Treatment is for medical complications occurring as a result of an elective abortion
    d. Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy
3. All appropriate forms relating to abortion must be completed by the designated party and the Contractor must retain these forms for seven years.

VIII. Behavioral Health Integration

A. General

1. Contractor must arrange for a robust care management program that meets NCQA and/or URAC accreditation standards and all requirements in this section to all Enrollees requiring intensive care management.
2. Contractor must work with MDHHS and PIHPs to share data and develop a process to produce, at intervals designated by MDHHS, a list of Enrollees who have significant behavioral health issues and complex physical comorbidities.

3. Contractor must report to MDHHS annually on the effectiveness of its intensive care management initiatives in a manner determined by MDHHS.

B. Provide or Arrange for Services

1. Primary Care Provider
   a. Contractor agrees to provide primary care training on evidence-based behavioral health service models for primary care providers, such as Screening, Brief Intervention and Referral to Treatment (SBIRT).
   b. Contractor agrees to reimburse its primary care practices for behavioral health screening services provided to Enrollees.
2. Community Health Workers (CHWs)
   a. Contractor must provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or peer-support specialist services. Examples of CHW services include but are not limited to:
      i. Conduct home visits to assess barriers to healthy living and accessing health care
      ii. Set up medical and behavioral health office visits
      iii. Explain the importance of scheduled visits to clients
      iv. Remind clients of scheduled visits multiple times
      v. Accompany clients to office visits, as necessary
      vi. Participate in office visits, as necessary
      vii. Advocate for clients with providers
      viii. Arrange for social services (such as housing and heating assistance) and surrounding support services
      ix. Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
      x. Help boost clients' morale and sense of self-worth
      xi. Provide clients with training in self-management skills
      xii. Provide clients with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting
      xiii. Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives
   b. Contractor agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by community health workers or peer support specialists to promote behavioral health integration.
   c. Contractor must maintain a CHW to Enrollee ratio of at least one full-time CHW per 20,000 Enrollees.
   d. Contractors must ensure CHWs are adequately equipped to serve Enrollees in the community, understand all privacy laws and HIPAA provisions, and have all core competencies, including:
      i. Role advocacy and outreach
      ii. Navigating community resources
      iii. Legal and ethical responsibilities
      iv. Teaching and capacity-building
      v. Communication skills and cultural responsiveness
      vi. Coordination, documentation and reporting
      vii. Healthy lifestyles.

C. Collaboration with Prepaid Inpatient Health Plans (PIHPs)

1. Coordinating Agreements between Contractors and Prepaid Inpatient Health Plans (PIHPs) must include the following:
    a. Contractor must maintain Coordinating Agreements (see Appendix 9 for model agreement) with all PIHPs in their service area (Coordinating PIHPs) for the purpose of referrals, care coordination, grievance and appeal resolution and the overall continuity of care for Enrollees served by PIHPs.
    b. Contractor must separately track and report all grievances and appeals for Enrollees jointly served by Contractor and PIHPs.
    c. Contractors must, in collaboration with Coordinating PIHPs, update the Coordinating Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually.
    d. Contractor must establish key contact personnel in each Coordinating PIHP and develop or jointly participate in a MDHHS-approved community-based public health initiative or project and report the project results to MDHHS.
        i. Contractor and Coordinating PIHPs must meet for this purpose at least quarterly.
        ii. Contractor and Coordinating PIHPs must include, to the extent possible, key clinical leads at CMHSPs and other stakeholders.
        iii. Contractor and Coordinating PIHPs must report projects and ongoing results to MDHHS at least annually.
2. Care Management Tools
    a. Contractor must designate key personnel to oversee the appropriate use of the MDHHS-supported web-based care management system, CareConnect360 (CC360). Contractor CC360 key personnel must include:
        i. One Super Managing Employee (SuME) with the authority to assign Managing Employees. MDHHS approval of the SuME is required
        ii. Managing Employees (not limited in number) with the authority to approve CC360 users, also approved by MDHHS through the Database Security Application (DSA)
    b. Contractors must maintain an electronic bidirectional exchange of information with each Coordinating PIHP (VIII-C).
3. Care Management and Quality Metrics for Shared Populations
    a. Contractor agrees to work collaboratively with PIHPs serving its Enrollees to meet the requirements in this section for identifying and coordinating the provision of services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.
    b. Contractor must work with the PIHPs to jointly create and implement a method for stratifying Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.
    c. Contractor must work with PIHPs to jointly develop care management standards for providing care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities based on patient needs and goals.
    d. Contractor must work with PIHPs to jointly develop and implement processes for providing coordinated complex care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.

e. Contractor must work with PIHPs to jointly create a care management tool used by staff from each organization to document a jointly created care plan and to track contacts, issues, and services regarding Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.

f. Contractor and PIHP care managers must hold case reviews at least monthly during which the care managers and other team members, including community health workers, pharmacists, medical directors and behavioral health providers, must discuss Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities, and develop shared care management interventions.

g. Contractor must work collaboratively with PIHPs, primary care providers, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.

h. Contractor agrees to report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.

4. Integration of Behavioral Health and Physical Health Services

a. Contractor must collaborate with PIHPs serving its Enrollees to improve integration of behavioral health and physical health services by meeting the following requirements:

1. Facilitate the placement of primary care clinicians in community mental health centers (CMHC) to enable Enrollees to receive both primary care services and behavioral health services at the location where they are most comfortable and incorporate principles of shared decision-making.

2. Facilitate placement of behavioral health clinicians in primary care settings and providing training on treating patients in a holistic manner, using a single treatment plan that addresses both physical and mental health needs and taking into account unmet needs such as substance abuse treatment; and also helping the individual access his/her natural community supports based on his/her strengths and preferences;

3. Develop and implement initiatives to improve communication and collaboration between Contractor's provider network and PIHP's contracted CMHSPs and other behavioral health providers.

IX. Patient-Centered Medical Home Expansion and Coordination with Accountable Systems of Care

In order to promote patient-centered medical homes (PCMH) as an integral component of the delivery system, Contractor must support the transformation of primary care practices into patient-centered medical homes and commit to increasing the percentage of Enrollees receiving services from PCMH-designated practices through the term of the contract.

A. PCMH expansion to support Population Health

1. Contractor must contract with primary care practices that are recognized as patient-centered medical homes by NCQA or BCBS of Michigan's Provider Group Incentive Program (PGIP), or under other PCMH standards approved by MDHHS.

2. Contractor must report to MDHHS semi-annually on the number and percentage of Enrollees receiving services from PCMH-designated practices (as described above), overall and for subpopulations in a manner determined by MDHHS.

3. Contractor must promote within PCMH practices Enrollee engagement and responsibilities by undertaking person-centered initiatives that:
    a. Improve access to behavioral health, dental care, community health workers, patient navigators, and health promotion and prevention programs delivered by community-based organizations, or social service programs from the clinical setting.
    b. Increase the rate of completed person/family-centered care plans for CHSCS and children in foster care.
    c. Increase the rate of person/family-centered care management plans for Enrollees with multiple co-morbid conditions, and
    d. Increase the proportion of Healthy Michigan Enrollees who complete a health risk assessment within a specified time period.

B. Support of Care Managers

1. Contractor must report semi-annually on the percentage of primary care practices with embedded or shared care managers and which of those practices are supported through the Michigan Primary Care Transformation Demonstration (MiPCT).
2. Contractor must establish standardized work processes between Contractor's care management staff and the embedded and shared care managers to promote coordination of services and to avoid duplication of services. Such work processes must include establishing a single point of contact between the health plan and an embedded care manager.

C. Blueprint for Health Innovation

1. As community-based initiatives funded by the Michigan Blueprint for Health Innovation develop in Contractor's service area, including Accountable Systems of Care (ASCs) and Community Health Innovation Regions, Contractor must participate in these initiatives.
2. Contractor must contract with ASCs in a manner consistent with the expectations outlined in this section. MDHHS may request documentation of how any contract between a Contractor and an ASC is consistent with the population health improvement obligations outlined in this section.

X. Population Health Management

A. Data Aggregation, Analysis and Dissemination

1. General
    a. Contractor recognizes that population health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age), and the distribution of health conditions, health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age).
    b. Contractor must develop and submit to MDHHS, at a date determined by MDHHS, a multi-year plan to incorporate social determinants of health into their process for analyzing data to support population health management as outlined in section X-A (2), including:
        i. Which determinants will be added
        ii. The manner in which social determinant data will be collected and analyzed for each Enrollee
        iii. The manner in which the social determinant risk determinations are validated

iv. The timeline for implementing the new factors into the data analysis to support population health management
v. The plan for training Contractor staff and embedded care managers on using the social determinants data incorporated into the data analysis

2. Data Analysis to Support Population Health Management
   a. Contractor must utilize information such as claims data, pharmacy data, and laboratory results, supplemented by UM data, health risk assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:
      i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.
      ii. Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.
      iii. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.
      iv. Persons with high prevalence Chronic Conditions, such as diabetes, obesity and cardiovascular disease.
      v. Enrollees in need of Complex Care Management, including high risk Enrollees with dual behavioral health and medical health diagnoses who are high utilizers of services.
      vi. Women with a high risk pregnancy.
      vii. Children eligible for the Children's Special Health Care Services (CSHCS) program.
      viii. People with Special Health Care Needs (PSHCN).
      ix. Other populations with unique needs as identified by MDHHS such as foster children or homeless members
   b. Data Analysis Update Requirements
      i. Contractor must systematically stratify newly enrolled Enrollees on a monthly basis.
      ii. Contractor must systematically re-stratify the entire Enrollee population, including the stratifications required in section X-A (2) Data Analysis to Support Population Health Management, at intervals designated by MDHHS to ensure Enrollees with increasing health risks and social needs are identified for population health management services.
      iii. Upon receiving MDHHS's approval of the plan to incorporate social determinants into their process for analyzing data to support population health management, the Contractor must submit semi-annual updates to MDHHS regarding plan implementation, noting compliance with respect to the plan timeline, the plan of correction to realign activities to the timeline, and timeline revisions, if necessary.

3. Data Submission and Data Reporting
   a. As requested by MDHHS, the Contractor must participate in initiatives to develop, implement within an agreed upon timeframe and continually

improve reports for primary care practices that will support practice activities to improve population health management, including, but not limited to an actionable list of Enrollees for primary care practices that identify the targeted populations listed in section X-A (2) Data Analysis to Support Population Health Management.

b. As requested by MDHHS, the Contractor must participate in initiatives to develop a core set of social determinants of health, community-based support service provision, utilization, and health outcomes that providers will submit to for inclusion in performance measure reports, including agreement on how the data must be submitted by providers in order to minimize the administrative burden.

c. Contractor must report to MDHHS and primary care providers, at intervals designated by MDHHS, on the effectiveness of its population health management initiatives in a manner determined by MDHHS.

d. Contractor must report on the effectiveness of its population health management initiatives including: Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level; Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention programs delivered by a community-based organization; changes in inpatient utilization, emergency department utilization, physician services and outpatient utilization, prescription drug utilization; outpatient CMHSP services; and selected health outcomes that are pertinent to the population served.

B. Addressing Health Disparities

1. General

a. Contractor recognizes that population health management interventions are designed to address the social determinants of health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve health equity.

b. Contractor must develop protocols for providing population health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings:

i. At adult and family shelters for Enrollees who are homeless
ii. The Enrollee's home
iii. The Enrollee's place of employment or school

c. Contractor must implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/.

2. Community Collaboration Project

a. Contractor must participate with a community-led initiative to improve population health in each region the Contractor serves. Examples of such collaborative initiatives include, but are not limited to community health needs assessments (CHNA) and community health improvements plans conducted by hospitals and local public health agencies or other regional health coalitions.

b. Contractors may propose the development of their own community collaboration initiative to improve population health if such initiatives do not exist in a particular region.

c. All community collaboration projects are subject to MDHHS approval prior to implementation.

3. Services Provided by Community-Based Organizations

a. Contractor must, to the extent applicable, enter into agreement with community-based organizations to coordinate population health improvement strategies in the Contractor's region which address the socioeconomic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management as needed and supported by evidence-based medicine and national best practices. Agreements must address the following topics:

i. Data sharing
ii. Roles/responsibilities and communication on development of care coordination plans
iii. Reporting requirements
iv. Quality assurance and quality improvement coordination
v. Plans for coordinating service delivery with primary care provider
vi. Payment arrangements

b. Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address social determinants of health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to:

i. Conduct home visits to assess barriers to healthy living and accessing health care
ii. Set up medical and behavioral health office visits
iii. Explain the importance of scheduled visits to clients
iv. Remind clients of scheduled visits multiple times
v. Accompany clients to office visits, as necessary
vi. Participate in office visits, as necessary
vii. Advocate for clients with providers
viii. Arrange for social services (such as housing and heating assistance) and surrounding support services
ix. Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
x. Help boost clients' morale and sense of self-worth
xi. Provide clients with training in self-management skills
xii. Provide clients with someone they can trust by being reliable, non-judgmental , consistent, open, and accepting
xiii. Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives

c. Contractor must maintain a CHW to Enrollee ratio of at least one full-time CHW per 20,000 Enrollees.

d. Contractors must ensure CHWs are adequately equipped to serve Enrollees in the community, understand all privacy laws and HIPAA provisions, and have all core competencies, including:

i. Role advocacy and outreach
ii. Navigating community resources
iii. Legal and ethical responsibilities
iv. Teaching and capacity-building
v. Communication skills and cultural responsiveness

vi. Coordination, documentation and reporting
vii. Healthy lifestyles

C. Health Promotion and Disease Prevention

1. General
   a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding: oral health, alcohol and substance use, tobacco use, healthy eating/physical activity, stress, and immunization status.
   b. Contractor recognizes that health promotion and disease prevention services must be offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population.
   c. Contractor must submit to MDHHS annually a report on its health promotion and disease prevention programs, including outreach, referral, and follow-up activities related to Enrollee uptake and participation rates.
2. Health Promotion and Disease Prevention Services
   a. Contractor must ensure its Enrollees have access to evidence-based/best practices educational programs, through Contractor programs or referral to local public health/community-based programs, that increase Enrollees' understanding of common risk factors, and evidence-based/best practices wellness programs to engage and track Enrollees' participation in activities that reduce the impact of common risk factors.
   b. Such education and wellness programs must be available to Enrollees through multiple sources, which may include but are not limited to websites, social media vehicles, in health care offices and facilities, public schools and through mailings.
   c. Contractor must implement educational, public relation and social media initiatives to increase Enrollee and network provider awareness of public health programs and other community-based resources that are available and designed to reduce the impact of social determinants of health and other common risk factors, such as the community-based public health resources designed to promote Enrollee wellness and available at http://www.michigan.gov/mdch/0,4612,7-132-2940_63445---,00.html.
   d. Contractor must collaborate with community-based organizations to facilitate the provision of Enrollee health education services to ensure the entire spectrum of psychosocial determinants of health are addressed (e.g. housing, healthy diet and physical activity, behavioral health).
3. Health Risk Assessments
   a. As established in P.A. 107 of 2013, Contractors are required to work with HMP Enrollees to assess health risk status and facilitate the adoption of healthy behaviors, specifically regarding: alcohol use, substance use disorders, tobacco use, obesity, and immunization status.
   b. The enrollment services contractor will conduct the initial HRA for HMP Enrollees via the telephone at the time of enrollment with the Contractor. HRA results will be transmitted via a secure gateway to the Contractor. Contractor may establish a secure mechanism to transmit the initial HRA results received from enrollment services contractor to the Enrollee's primary care physician prior to or during the Enrollee's first visit with the PCP.

c. Contractors must facilitate all HMP Enrollees in having an annual health risk assessment (HRA) and ensure all HMP Enrollees receive a copy of the HRA upon initial enrollment with the Contractor.
d. Contractor must establish, implement and provide healthy behavior incentives and assessments in accordance with this Contract and the CMS-approved Healthy Behaviors Incentives Operational Protocol.
e. Contractor must facilitate the timely receipt of an Enrollees' initial appointment with their PCP.
f. Contractor must establish a mechanism for obtaining the completed HRA, including PCP attestation, from the PCP.
g. Contractor must establish HRA incentives for members and providers in accordance with the CMS-approved Healthy Behaviors Incentives Operational Protocol.
h. Contractors must educate network providers about the initial appointment standards, the HRA process and the required PCP attestation that the HRA was completed and the Enrollee set healthy behavior goals.
i. Contractor must store the results of the HRA and the healthy behavior goals set by the Enrollee.
j. Contractor must fully cooperate with all MDHHS monitoring of the healthy behavior incentives and assessment programs, in accordance with the CMS-approved Healthy Behaviors Incentives Operational Protocol.

D. Providing Care Management Services and Other Targeted Interventions

1. Care Management Services

a. Contractor must create risk stratification to identify Enrollees by population or sub-population who qualify for intensive care management service, moderate intensity care management services and low intensity care management services.

b. Contractor must offer a robust care management program that meets NCQA and/or URAC accreditation standards to Enrollees who qualify for those services, and other subpopulations as designated by MDHHS, including but not limited to disabled populations, high-risk pregnancies, children with elevated blood lead, and chronic condition-specific populations.

c. Contractor must, to the extent possible, coordinate with other care managers and supports coordinators.
d. Contractor must refer Enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments.
e. Annually, the Contractor must report to MDHHS the percentage of Enrollees that are eligible for and receiving each care management service level.
f. Contractor must report to MDHHS, at intervals designated by MDHHS, on the effectiveness of its care management initiatives implemented.
g. CSHCS Enrollee
   i. Contractor must assess the need for a care manager and a family-centered care plan developed in conjunction with the family and care team
   ii. Contractors must collaborate with the family and established primary and specialty care providers to assure access to the most appropriate provider for the Enrollee.

iii. Contractor must have separate, specific PA procedures for CSHCS Enrollees.
(1) In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, Contractors must accept prior authorizations in place when the CSHCS Enrollee is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractors must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization.
(2) Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services.
iv. Contractors must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of such equipment.

h. Persons with Special Health Care Needs
Contractor is required to do the following for members identified by MDHHS as persons with special health care needs:
i. Conduct an assessment in order to identify any special conditions that require ongoing case management services for the Enrollee.
ii. Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.
iii. For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the Enrollee.

2. Targeted Interventions for Subpopulations Experiencing Health Disparities:
a. Contractor must offer evidence-based interventions that have a demonstrated ability to address social determinants of health and reduce health disparities to all individuals who qualify for those services.
b. Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions. To the extent that ASCs are functioning within the Contractor's service area, the Contractor must collaborate with ASCs to develop, promote, and implement these targeted evidence-based interventions.
c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.
d. Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce health disparities by considering such measures as number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level, number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a community-based organization, and changes in Enrollee biometrics and self-reported health status.

XI. Quality Improvement and Program Development

A. Quality Assessment and Performance Improvement Program (QAPI)

1. Contractor must have an ongoing QAPI program for the services furnished to its Enrollees that meets the requirements of 42 CFR 438.240.
2. Contractor's Medical Director must be responsible for managing the QAPI program.
3. Contractor must maintain a Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including but not limited to the Quality Improvement Director and other key management staff, as well as health professionals providing care to Enrollees.
4. Contractor's QAPI program must:
    a. Incorporate activities required in Section X. Population Health Management into their QAPI program
    b. Identify opportunities to improve the provision of health care services and the outcomes of such care for Enrollees
    c. Incorporate and address findings of compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies
    d. Develop or adopt performance improvement goals, objectives, and activities or interventions to improve service delivery or health outcomes for Enrollees.
    e. Be made available to MDHHS annually through the compliance review or on request
5. Contractor must have a written plan for the QAPI program that includes, at a minimum, the following:
    a. Contractor's performance goals and objectives
    b. Lines of authority and accountability
    c. Data responsibilities
    d. Performance improvement activities
    e. Evaluation tools
6. The written plan must describe how the Contractor must:
    a. Analyze the processes and outcomes of care using currently accepted standards from recognized medical authorities. The Contractor may include examples of focused review of individual cases, as appropriate
    b. Analyze data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees
    c. Develop system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of emergency services
    d. Use measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies, and outcomes of care. Contractor must collect and use data from multiple sources such as HEDIS®, medical records, encounter data, claims processing, grievances, utilization review, and member satisfaction instruments in this activity
    e. Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement and integrate the work of the Community Collaboration Project into their overall QAPI program
    f. Compare QAPI program findings with past performance and with established program goals and available external standards

g. Measure the performance of providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers
h. At least annually, provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor
i. Develop and/or adopt, and periodically review, clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards and makes these clinical practice guidelines available to Enrollees upon request
j. Ensure that where applicable, utilization management, Enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines
k. Evaluate access to care for Enrollees according to the established standards and those developed by MDHHS and Contractor's QIC and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities
l. Perform a member satisfaction survey according to MDHHS specifications and distribute results to providers, Enrollees, and MDHHS
m. Implement improvement strategies related to program findings and evaluate progress at least annually
n. Ensure the equitable distribution of health care services to their entire population, including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities
o. Collect and report data as proscribed by MDHHS including but not limited HEDIS®, CAHPS, and other MDHHS-defined measures that will aid in the evaluation of quality of care of all populations
p. Defining roles, responsibilities, and procedures for monitoring and continuously improving the following activities:
    i. Case Management/Disease Management
    ii. Health promotion and disease prevention
    iii. Interventions targeting subpopulations experiencing health disparities
    iv. Interventions addressing the social determinants of health

B. Annual Effectiveness Review

Contractor must conduct an annual effectiveness review of its QAPI program that includes:

1. Analysis of improvements in the access and quality of health care and services for Enrollees as a result of quality assessment and improvement activities and targeted interventions carried out by the Contractor.
2. Consideration of trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.
3. Information on the effectiveness of the Contractor's QAPI program must be provided annually to network providers, up request to Enrollees, and annually to MDHHS through the compliance review or upon request.

C. Annual Performance Improvement Projects

1. Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas.

2. Contractor must meet minimum performance objectives. Contractor may be required to participate in statewide performance improvement projects that cover clinical and non-clinical areas that may include but are not limited to examination of disparate access, utilization, or outcomes.
3. MDHHS must collaborate with stakeholders and the Contractor to determine priority areas for statewide performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the population such as care of children, pregnant women, and persons with special health care needs, as defined by MDHHS.
4. Contractor must assess performance for the priority areas identified by the collaboration of MDHHS and other stakeholders.

D. Performance Monitoring

MDHHS has established annual performance monitoring standards.

1. Contractor must incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QAPI program.
2. MDHHS may use the results of performance assessments as part of the formula for bonus awards and/or automatic enrollment assignments. MDHHS will continually monitor the Contractor's performance on the performance monitoring standards and make changes as appropriate. The performance monitoring standards are attached to the Contract (Appendix 4); the performance bonus documents are attached to the Contract (Appendix 5a-5e).

E. External Quality Review

MDHHS will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the Contractor. Contractor must:

1. Address the findings of the external review through its QAPI program.
2. Develop and implement performance improvement goals, objectives, and activities in response to the External Quality Review (EQR) findings as part of the Contractor's written plan for the QAPI.
3. Participate fully and completely with all EQR-related activities as specified by MDHHS and/or federal regulations.

F. Consumer Survey

1. Contractor must conduct an annual survey of their adult Enrollee population using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument.
2. Contractor must directly contract with a National Committee for Quality Assurance (NCQA) certified CAHPS® vendor and submit the data according to the specifications established by NCQA.
3. Contractor must provide NCQA summary and member level data to MDHHS annually.
4. Contractor must provide an electronic or hard copy of the final survey analysis report to MDHHS upon request.

G. Medicaid Health Equity Project

Contractor must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

H. Utilization Management

1. The utilization management (UM) activities of the Contractor must be integrated with the Contractor's QAPI program.
2. The major components of Contractor's UM program must encompass, at a minimum, the following:
    a. Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
    b. A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

c. Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

3. An annual review and reporting of utilization review activities and outcomes/interventions from the review. Contractor must establish and use a written prior approval policy and procedure for UM purposes.
   a. The policy must ensure the review criteria for authorization decisions are applied consistently and require the reviewer consult with the requesting provider when appropriate.
   b. The policy must also require UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. For prior authorization decisions related to CSHCS Enrollees, Contractors are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals and ancillary providers available and appropriate to render services to CSHCS Enrollees. Contractor is also encouraged to utilize Office of Medical Affairs Medical Consultants for assistance in determining appropriate durable medical equipment for CSHCS Enrollees.
4. Contractor must not use UM policies and procedures to avoid providing medically necessary services within the coverages established under the Contract.
5. Contractor's authorization policy must establish timeframes for standard and expedited authorization decisions.
   a. These timeframes may not exceed 14 calendar days from date of receipt for standard authorization decisions and 3 working days from date of receipt for expedited authorization decisions.
   b. These timeframes may be extended up to 14 additional calendar days if requested by the provider or Enrollee and the Contractor justifies the need for additional information and explains how the extension is in the Enrollee's interest. The Enrollee must be notified in writing of the plan's intent to extend the timeframe.
6. Contractor must ensure that compensation to the individuals or subcontractor that conduct utilization management activities is not structured so as to provide incentives for the individual or subcontractor to deny, limit, or discontinue medically necessary services to any Enrollee. If an authorization decision is not made within the specific timeframes, the Contractor must issue an adverse action notice.

I. Benefits Monitoring Program

1. Contractor must utilize a systematic method for the identification of Enrollees who meet the criteria for the Benefits Monitoring Program (BMP) under Medicaid policy.
2. Contractors must utilize the BMP-PROM system for the identification of BMP candidates.
3. Upon determination of BMP enrollment, the Contractor must notify the Enrollee that she/he will be placed in the BMP and provide an effective date of no less than 12 days after notification.
4. Upon determination of BMP enrollment, the Contractor may assign a provider and/or a pharmacy to the Enrollee. Contractor must notify the Enrollee of this assignment and provide an effective date of no less than 12 days after notification.
5. Contractor must participate in MDHHS Fair Hearings that result if the Enrollee appeals any adverse action while the Enrollee is in BMP.
6. Upon enrollment in the BMP, the Contractor must provide education to the Enrollee on the correct utilization of services.
7. Contractor must assist the Enrollee to remove barriers to the Enrollee's correct utilization of services and make the appropriate referrals to behavioral health and substance use disorder providers when appropriate.

8. Contractor must systematically monitor the Enrollee's utilization of services to determine whether the enrollment in BMP and education have modified the Enrollee's behavior.
9. Contractor must establish timelines consistent with Medicaid policy for the review of each Enrollee in BMP to determine if the Enrollee has met goals and guidelines and may be removed from BMP.
10. All remedies and sanctions must be allowed by Medicaid policy and State and federal law. Prior to implementing new remedies and sanctions, the Contractor must obtain written approval from MDHHS.

J. Contractor Compliance Reviews

1. Contractor compliance reviews by MDHHS will be an ongoing activity conducted during the Contract. Contractor's compliance review will include a desk audit and on-site focus component. The compliance review will focus on specific areas of health plan performance as determined by MDHHS. These focus areas may include, but are not limited to the following:
    a. Administrative capabilities
    b. Governing body
    c. Subcontracts
    d. Transportation
    e. Coordination of care with MIHP provider organizations
    f. Care management and coordination for CSCHS Enrollees
    g. Provider network capacity and services
    h. Provider appeals
    i. Member services
    j. Primary care provider assignments and changes
    k. Enrollee grievances and appeals
    l. Health education and promotion
    m. Population health
    n. Value-based payment
    o. HIE/HIT
    p. Quality assessment and performance improvement
    q. Utilization review
    r. Data analysis and reporting
    s. Coordination of care with behavioral health providers
    t. Claims processing
    u. Fraud, waste, and abuse
    v. MI Health Account Operational Protocol
    w. Healthy Behaviors Incentives Operational Protocol
2. MDHHS will determine if the Contractor meets contractual requirements and assess health plan compliance. MDHHS reserves the right to conduct a comprehensive compliance review.

K. Contract Remedies and Sanctions

1. MDHHS must utilize a variety of means to assure compliance with Contract requirements. MDHHS will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented.
2. MDHHS may employ Contract remedies and/or sanctions to address any Contractor noncompliance with the Contract. Areas of noncompliance for which MDHHS may impose remedies and sanctions include, but are not limited to, noncompliance with Contract requirements on the following issues:
    a. Marketing practices
    b. Member services
    c. Provision of medically necessary, covered services

d. Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services
e. Provider networks
f. Provider payments
g. Financial requirements including but not limited to failure to comply with physician incentive plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program
h. Enrollee satisfaction
i. MI Health Account services and practices including compliance with the CMS approved Operational Protocol for MI Health Accounts
j. Healthy Behavior policies and procedures including compliance with the CMS approved Operational Protocol for Healthy Behaviors
k. Performance standards included in Appendix 4 to the Contract
l. Misrepresentation or false information provided to MDHHS, CMS, providers, Enrollees, or potential Enrollees
m. URAC or NCQA accreditation
n. Certificate of Authority
o. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

3. MDHHS may utilize intermediate sanctions (as described in 42 CFR 438.700) that may include the following:
   a. Civil monetary penalties in the following specified amounts:
      1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, potential Enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
      2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
      3. A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
      4. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging copayments in excess of the amounts permitted under the Medicaid program. The State will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s).
   b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706. If a temporary management sanction is imposed, MDHHS will work concurrently with DIFS.
   c. Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.
   d. Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the sanction.
   e. Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
   f. Additional sanctions allowed under state statute or regulation that address areas of noncompliance.
4. If intermediate sanctions or general remedies are not successful or MDHHS determines that immediate termination of the Contract is appropriate, as allowed by Standard Contract Term provisions 24 and 25, the State may terminate the Contract with the Contractor. Contractor must be afforded a hearing before termination of a Contract under this Section can occur. The State must notify

Enrollees of such a hearing and allow Enrollees to disenroll, without cause, if they choose.

5. In addition to the sanctions described above, MDHHS may impose a monetary penalty of not more than $5,000.00 to a Contractor for each repeated failure on any of the findings of MDHHS compliance review.

XII. Cost-Sharing Requirements

A. Copayments for Medicaid Enrollees

1. Contractor may require copayments from Enrollees, consistent with State and federal guidelines and Medicaid Policy upon approval from MDHHS
2. Contractor's must inform Enrollees of copayment obligations upon enrollment and upon any changes to copayment requirements
3. Copayment requirements must be listed and explained in the member handbook.
4. Enrollees cannot be denied services based on their inability to pay copayments.

B. Healthy Michigan Plan (HMP)

1. Operation of Enrollee MI Health Accounts is delegated to a vendor.
2. Contractor must establish, maintain and monitor a contract with the MDHHS-designated MI Health Account Vendor. The Contract must include, at a minimum, the following provisions:
    i. Statement of work
    ii. Term of contract
    iii. Termination provisions
    iv. Payment provisions
    v. Dispute resolution
3. Contractor must monitor the MI Health Account vendor through reports provided by the vendor and quarterly oversight meetings.
4. Copayments
    a. Copayments for HMP Enrollees must be identical in amounts and applicable services to copayments for FFS as specified in Medicaid policy.
    b. No copayments must be collected for six months following initial enrollment with an HMP Contractor.
    c. Following the initial six-month period, the Contractor must collect a monthly copayment fee equal to the average copayments for services paid by the Contractor in the previous six months.
    d. HMP Enrollees will <u>not</u> remit copayments at point of service for services covered under the contract.
    e. Contractor must recalculate the monthly copayment amount due every six months based on claims paid during the previous the six-month period and include the copayments charged and the monthly copayment amount due on the quarterly MI Health Account Statement as specified below.
5. Enrollee Contributions
    a. As established 107 P.A. 2013, HMP Enrollees with incomes above 100% of the federal poverty level (FPL) must contribute 2% of their income annually to their health care costs.
    b. HMP Enrollees will not have a required contribution for six months after enrollment with the first Contractor upon gaining HMP eligibility. Transfer from one Contractor to another Contractor after initial enrollment will not impact Enrollee contribution requirements.
    c. Contractors must not request disenrollment for Enrollees' failure to remit required contributions.

XIII. Enrollee Services

A. Enrollee Rights

1. Contractor must develop and maintain a written policy regarding Enrollee rights and communicate these rights to Enrollees in the member handbook. The Enrollee rights must include, at a minimum, the Enrollee's right to:
    a. Be treated with dignity and respect
    b. Receive culturally and linguistically appropriate services
    c. Confidentiality
    d. Participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about treatment options
    e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
    f. Request and receive a copy of his or her medical records, and request those be amended or corrected
    g. Be furnished health care services consistent with this Contract and State and federal regulations
    h. Be free to exercise his or her rights without adversely affecting the way the Contractor, providers, or the State treats the Enrollee
    i. Be free from other discrimination prohibited by State and federal regulations

B. Informational Materials for Enrollees

1. Contractor must use only MDHHS-approved materials and information relating to benefits, coverage, enrollment, grievances, appeals, or other administrative and service functions, such as handbooks, newsletters, and other member enrollment materials.
    a. Contractor may reuse a letter template previously approved by MDHHS without obtaining additional approval.
    b. Upon receipt by MDHHS of a complete request for approval of the proposed informational materials or communication, MDHHS must provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved.
    c. Informational materials must be written at a 6.9 grade reading level or lower.
2. Contractors must address the need for culturally appropriate interventions for all Enrollee services.
3. Contractor must make reasonable accommodations for Enrollees with hearing and/or vision impairments (e.g. signing video for deaf and hard of hearing).
4. Contractor must make oral interpretation services available to all Enrollees free of charge; applicable to all non-English languages, not just those languages that meet the definition of prevalent language under this Contract.
5. Contractor must establish and maintain a toll-free 24 hours per day, 7 days per week telephone number to assist Enrollees.
6. Contractor must issue to all Enrollees an eligibility card that includes:
    a. The toll-free 24 hours per day, 7 days per week phone number stated above
    b. The Enrollee's Medicaid ID number
    c. The Enrollee's PCP name and phone number. Contractors must meet this requirement in one of the following ways:
        i. Print the PCP name and phone number on the card; the Contractor must send a new card to the Enrollee when the PCP assignment changes.

ii. Print the PCP name and phone number on a replaceable sticker to be attached to the card; the Contractor must send a new sticker to the Enrollee when the PCP assignment changes.
iii. Any other method approved by MDHHS, provided that the PCP name and phone number is affixed to the card and the information is updated when the PCP assignment changes.

7. Contractor may submit a weekly PCP Submission Update File that includes all PCP changes and additions made by the Contractor during that week. If the Contractor submits an update file each week, the Contractor is not required to include the member's PCP name and phone number on the member identification card.

C. Enrollee Education

1. Contractor must make available to all Enrollees appropriate, culturally responsive educational materials to promote health, mitigate the risks for specific conditions, and manage existing conditions. Materials for Enrollee education should include:
   a. Member handbook
   b. Contractor bulletins or newsletters sent to Enrollees at least two times per year that provide updates related to covered services, access to providers, and updated policies and procedures
   c. Literature regarding health and wellness promotion programs offered by the Contractor
   d. A website, maintained by the Contractor, that includes information on
      i. Preventive health strategies
      ii. Health and wellness promotion programs offered by the Contractor
      iii. Updates related to covered services and access to providers
      iv. Complete provider directory, and
      v. Updated policies and procedures
   e. Information regarding the appropriate use of health services and prevention of fraud, waste, and abuse
2. Contractor must make health promotion programs available to the Enrollees.
3. Contractor may provide health education to Enrollees, including health screens, in a provider office provided the health education meet all of the following criteria:
   a. If a member incentive is offered it must be delivered in separate private room.
   b. No advertisement of the event may be present or distributed in the provider office.
   c. Only Contractors' Enrollees may participate

D. Services for CSHCS Enrollees

1. Contractor must designate specific member services staff to assist CSHCS Enrollees and provide these member services staff with additional training needed to accommodate the special needs of CSHCS Enrollees. CSHCS Enrollees and family should be able to access the specially trained member services staff directly.
2. Contractor must provide targeted outreach and education to CSHCS Enrollees, including specific information on navigating the managed health care system and CSHCS-specific member services available.
3. Contractor must establish and maintain educational content and outreach information on the Contractor's web site specifically directed to CSHCS Enrollees with a mechanism for CSHCS Enrollees and family to contact specially-trained staff to assist them.
4. Contractor must establish and maintain written policies and procedures that provide Enrollees and families the opportunity to provide input on Contractor policies and procedures that influence access to medical services or member services. Contractors are encouraged to develop forums for discussion between the CSHCS Enrollees and families and the Contractor.

E. Member Materials

1. Member Identification Card
   a. Contractor must mail member ID cards to Enrollees via first class mail within 10 business days of being notified of the Enrollee's enrollment
   b. All other printed information, not including the member ID card, but including member handbook and information regarding accessing services may be mailed separately from the ID card
      i. Member materials stated above need not be mailed via first class but must be mailed within 10 business days of being notified of the member's enrollment.
      ii. Contractor may distribute new member packets to each household instead of to each individual member in the household, provided that the mailing includes individual health plan membership cards for each member enrolled in the household when ID cards and other member information are mailed together.
   c. Notification must be provided to affected Enrollees when programs or service sites change at least 10 business days prior to changes taking effect.
2. Member Handbook
   a. Contractor's member handbook must be written at no higher than a 6.9 grade reading level and be available in alternative formats for Enrollees with special needs.
   b. Member handbooks must be available in a prevalent language when more than 5% of the Contractor's Enrollees speak a prevalent language, as defined by MDHHS policy.
   c. Contractor must provide a mechanism for Enrollees who are blind or deaf and hard of hearing or who speak a prevalent language as described above to obtain member materials and a mechanism for Enrollees to obtain assistance with interpretation.
   d. Contractor must agree to make modifications in the handbook language to comply with the specifications of this Contract.
   e. Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least once a year and updated when necessary.
   f. At a minimum, the member handbook must include the following information as specified in 42 CFR 438.10(f)(2) and any other information required by MDHHS:
      i. Table of contents
      ii. Advance directives, including, at a minimum: (1) information about the Contractor's advance directives policy, (2) information regarding the State's advance directives provisions and (3) directions on how to file a complaint with the State concerning noncompliance with the advance directive requirements. Any changes in the State law must be updated in this written information no later than 90 days following the effective date of the change. In addition, for HMP Enrollees: (1) the MDHHS approved Advance Directive Form with information on how to complete the form and contact information for assistance with form completion, and (2) a postage-paid envelope addressed to the Peace of Mind Registry
      iii. Availability and process for accessing covered services that are not the responsibility of the Contractor, but are available to its Enrollees
      iv. Description of all available Contract services

v. Description of copayment requirements
vi. Designation of specialists as a PCP
vii. Enrollees' rights and responsibilities which must include all Enrollee rights specified in 42 CFR 438.100 (a)(1), 42 CFR 438.100(c), and 42 CFR 438 102(a). The Enrollee rights information must include a statement that conveys that Contractor staff and affiliated providers will comply with all requirements concerning Enrollee rights
viii. Enrollees' right to direct access to network women health specialists and pediatric providers for routine and preventive health care services without a referral
ix. Enrollees' right to receive FQHC services
x. Enrollees' right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
xi. Enrollees' right to request information on the structure and operation of the Contractor
xii. Explanation of any service limitations or exclusions from coverage
xiii. Explanation of counseling or referral services that the Contractor elects not to provide, reimburse for, or provide coverage of, because of an objection on moral or religious grounds. The explanation must include information on how the Enrollee may access these services
xiv. Fair Hearing process including that access may occur without first going through the Contractor's grievance/appeal process
xv. Grievance and appeal process including how to register a grievance with the Contractor and the State, how to file a written appeal, and the deadlines for filing an appeal and an expedited appeal
xvi. How Enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior
xvii. How to access hospice services
xviii. How to choose and change PCPs
xix. How to contact the Contractor's Member Services and a description of its function
xx. How to access out-of-county and out-of-state services
xxi. How to make, change, and cancel appointments with a PCP
xxii. How to obtain emergency transportation
xxiii. How to obtain non-emergent transportation covered under this contract
xxiv. How to obtain medically-necessary durable medical equipment (or customized durable medical equipment)
xxv. How to obtain oral interpretation services for all languages, not just prevalent languages as defined by the Contract
xxvi. How to obtain written information in prevalent languages, as defined by the Contract
xxvii. How to obtain written materials in alternative formats for Enrollees with special needs
xxviii. How to access community-based supports and services in Enrollees' service area

xxix. Contractor's toll-free numbers, including the toll-free number Enrollees use to file a grievance or appeal
xxx. Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant
xxxi. Process of referral to specialists and other providers
xxxii. Signs of substance use problems, available substance use disorder services and accessing substance use disorder services
xxxiii. Vision services, family planning services, and how to access these services
xxxiv. Well-child care, immunizations, and follow-up services for Enrollees under age 21 (EPSDT)
xxxv. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations
xxxvi. What to do when family size changes
xxxvii. WIC Supplemental Food and Nutrition Program
xxxviii. Any other information deemed essential by the Contractor and/or MDHHS

F. Provider Directory
1. Contractor must maintain a complete provider directory, reviewed for accuracy at least monthly, including written and web-based directories.
2. Contractor must provide the provider directory in a manner agreeable to the Enrollee either by mail or by utilizing the Contractor's web site.
3. Contractor's provider directory must contain, at a minimum, the following information:
   a. PCPs and specialists listed by county containing the following information: provider name, address, telephone number, any hospital affiliation, whether the provider is accepting new patients, languages spoken and gender.
   b. A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers Enrollees may need; the list must contain the address and phone number of the provider. Ancillary providers that are part of a retail chain may be listed by the name of the chain without listing each specific site.
4. Contractors must maintain full compliance with the office hour information on the 4275 provider file or list days and hours of operation on the PCP listing in the provider directory.

G. Grievance and Appeal Process for Enrollees
1. Grievance and Appeal Policies and Procedures
   a. Contractor must establish and maintain an internal process for the resolution of grievances and appeals from Enrollees.
   b. Contractor must have written policies and procedures governing the resolution of grievances and appeals; Enrollees may file a grievance or appeal, orally or in writing, on any aspect of covered services as specified in the definitions of grievance and appeal.
   c. MDHHS must approve Contractor's grievance and appeal policies prior to implementation. These written policies and procedures will meet the following requirements:
      i. Except as specifically exempted in this Section, the Contractor must administer an internal grievance and appeal procedure according

to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F)

ii. Contractor must cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act"

iii. Contractor must make a decision on non-expedited grievances or appeals within 35 calendar days of receipt of the grievance or appeal. This timeframe may be extended up to 10 business days if the Enrollee requests an extension or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the Enrollee's interest. If the Contractor utilizes the extension, the Contractor must give the Enrollee written notice of the reason for the delay. The Contractor may not toll (suspend) the time frame for grievance or appeal decisions other than as described in this Section

iv. If a grievance or appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the beneficiary, the 35-day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the beneficiary that an authorized representative form or document is required. For purposes of this Section "third party" includes, but is not limited to, health care providers

2. Grievance and Appeal Procedure Requirements

Contractor's internal grievance and appeal procedure must include the following components:

a. Allow Enrollees 90 days from the date of the adverse action notice within which to file an appeal under the Contractor's internal grievance and appeal procedure.

b. Give Enrollees assistance in completing forms and taking other procedural steps. Contractor must provide interpreter services and TTY/TDD toll-free numbers.

c. Acknowledge receipt of each grievance and appeal

d. Ensure that the individuals who make decisions on grievances and appeals are individuals who:

i. Are not involved in any previous level of review or decision-making, and

ii. Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the grievance or appeal involves a clinical issue. In reviewing appeals for CSHCS Enrollees, the Contractor should utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate or limit pediatric subspecialist provider services.

e. Provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

f. Allow the Enrollee and representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records

g. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the appeal.

h. Notify the Enrollee in writing of the Contractor's decision on the grievance or appeal.

3. Notice to Enrollees of Grievance Procedure

a. Contractor must inform Enrollees about the Contractor's internal grievance procedures at the time of initial enrollment and any other time an Enrollee expresses dissatisfaction by filing a grievance with the Contractor.
b. The internal grievance procedures information will be included in the member handbook and will explain:
   i. How to file a grievance with the Contractor
   ii. The internal grievance resolution process

4. Notice to Enrollees of Appeal Procedure
   a. Contractor must inform Enrollees of the Contractor's appeal procedure at the time of initial enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to appeal under the definition of appeal in this Contract.
   b. The appeal procedure information will be included in the member handbook and will explain:
      i. How to file an appeal with the Contractor
      ii. The internal appeal process
      iii. The member's right to a Fair Hearing with the State
5. Contractor Decisions Subject to Appeal
   a. When the Contractor makes a decision subject to appeal, as defined in this Contract, the Contractor must provide a written adverse action notice to the Enrollee and the requesting provider, if applicable.
   b. Adverse action notices for the suspension, reduction or termination of services must be made at least 12 days prior to the change in services. Contractor must continue the Enrollee's benefits if all of the following conditions apply:
      i. The appeal is filed timely, meaning on or before the later of the following:
         (1) Within 10 days of the Contractor's mailing the notice of action
         (2) The intended effective date of the Contractor's proposed action
      ii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
      iii. The services were ordered by an authorized provider
      iv. The authorization period has not expired
      v. The Enrollee requests extension of benefits
   c. If the Contractor continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
      i. The Enrollee withdraws the appeal.
      ii. The Enrollee does not request a fair hearing within 10 days from when the Contractor mails an adverse decision.
      iii. A State Fair Hearing decision adverse to the Enrollee is made.
      iv. The authorization expires or authorization service limits are met.
   d. If the Contractor reverses the adverse action decision or the decision is reversed by a State Fair Hearing, the Contractor must pay for services provided while the appeal was pending and authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.
6. Adverse Action Notice
   a. Adverse action notices involving service authorization decisions that deny or limit services must be made within the time frames described in this section (XIII-G). Adverse action notices pursuant to claim denials

must be sent on the date of claim denial. The notice must include the following components:

i. The action the Contractor or Subcontractor has taken or intends to take
ii. The reasons for the action
iii. The Enrollee's or provider's right to file an appeal
iv. An explanation of the Contractor's appeal process
v. The Enrollee's right to request a Fair Hearing
vi. The circumstances under which expedited resolution is available and how to request it
vii. The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services

b. Written adverse action notices must also meet the following criteria:

i. Be translated for the individuals who speak prevalent non-English languages as defined by the contract
ii. Include language clarifying that oral interpretation is available for all languages and how the Enrollee can access oral interpretation services
iii. Use easily understood language written below the 6.9 reading level
iv. Use an easily understood format
v. Be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs

7. State Medicaid Appeal Process

a. The State must maintain a Fair Hearing process to ensure Enrollees have the opportunity to appeal decisions directly to the State. Any Enrollee dissatisfied with a State agency determination denying an Enrollee's request to transfer Contractors/disenroll has access to a State Fair Hearing.

b. Contractor must include the Fair Hearing process as part of the written internal process for resolution of appeals and must describe the Fair Hearing process in the member handbook. The parties to the State Fair Hearing may include the Contractor as well as the Enrollee and her or his representative or the representative of a deceased Enrollee's estate.

8. Expedited Appeal Process

Contractor's written policies and procedures governing the resolution of appeals must include provisions for the resolution of expedited appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:

a. The Enrollee or provider may file an expedited appeal either orally or in writing.
b. The Enrollee or provider must file a request for an expedited appeal within 10 days of the adverse determination.
c. Contractor must make a decision on the expedited appeal within 72 hours of receipt of the expedited appeal. If the Enrollee requests an extension, the Contractor should transfer the appeal to the standard 35-day time frame and give the Enrollee written notice of the transfer within 2 days of the extension request.
d. Contractor must give the Enrollee oral and written notice of the appeal review decision.
e. If the Contractor denies the request for an expedited appeal, the Contractor must transfer the appeal to the standard 35-day timeframe

and give the Enrollee written notice of the denial within 2 days of the expedited appeal request.

f. Contractor must not take any punitive actions toward a provider who requests or supports an expedited appeal on behalf of an Enrollee.

XIV. Provider Services

A. Provider Services

1. Contractor must provide contract and education services for the provider network, including education regarding fraud and abuse
2. Contractor must properly maintain medical records
3. Contractor must process provider grievances and appeals in accordance with contract and regulatory requirements
4. Contractor must develop and maintain an appeal system to resolve claim and authorization disputes
5. Contractor must maintain a written plan detailing methods of provider recruitment and education regarding Contractor policies and procedures
6. Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, or a regular provider newsletter
7. Contractor must provide a staff of sufficient size to respond timely to provider inquiries, questions, and concerns regarding covered services
8. Contractor must provide a copy of the Contractor's prior authorization policies to the provider when the provider joins the Contractor's provider network. Contractor must notify providers of any changes to prior authorization policies as changes are made
9. Contractor must make available provider policies, procedures and appeal processes via Contractor website. Updates to the policies and procedures must be available on the website as well as through other media used by the Contractor
10. Contractor must promote among primary care providers the Michigan Health and Wellness 4 X 4 Plan including:
    a. Four key healthy behaviors
        i. Maintain a healthy diet
        ii. Engage in regular exercise
        iii. Annual physical exam
        iv. Avoid all tobacco use
    b. Four key health measures
        i. Body mass index (BMI)
        ii. Blood pressure
        iii. Cholesterol level
        iv. Blood glucose level

B. Provider Contracts

Contractor must comply with the following provisions and include the following information in provider contracts:

1. Prohibit the provider from seeking payment from the Enrollee for any covered services provided to the Enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered
2. Require the provider to cooperate with Contractor's quality improvement and utilization review activities
3. Include provisions for the immediate transfer of Enrollees to another Contractor PCP if their health or safety is in jeopardy
4. Include provisions stating that providers are not prohibited from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor

5. Include provisions stating that providers, acting within the lawful scope of practice, are not prohibited, or otherwise restricted, from advising or advocating on behalf of an Enrollee who is his or her patient:
    a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    b. For any information the Enrollee needs in order to decide among all relevant treatment options
    c. For the risks, benefits, and consequences of treatment or non-treatment
    d. For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
6. Require providers to meet Medicaid accessibility standards as defined in this Contract
7. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider
8. If the Contractor utilizes copayments for the covered service, prohibit the provider from denying services to Enrollee's based on their inability to pay the copayment
9. Ensure hospital contracts contain a provision that mandates the hospital to comply with all medical record requirements contained within (42 CFR 456.101-145)
10. Require providers to take Enrollees' rights into account when providing services as outlined in 42 CFR 438.100
11. Ensure Enrollees are not denied a covered service or availability of a facility or provider identified in this Contract
12. Require providers to not intentionally segregate Enrollees in any way from other persons receiving health care services
13. Require health professionals to comply with reporting requirements for communicable disease and other health indicators as mandated by State law

C. Provider Participation

1. Contractors must not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification.
2. This provision should not be construed as an "any willing provider" law, as it does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Enrollees.
3. This provision does not interfere with measures established by the Contractor designed to maintain quality and control costs consistent with the responsibility of the organization.
4. If Contractor declines to include providers in-network, the Contractor must give the affected providers written notice of the reason for the decision.

D. Provision of Grievance, Appeal and Fair Hearing Procedures to Providers

Contractor must provide the following Enrollee grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

1. The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing
2. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing
3. The availability of assistance to the Enrollee in filing
4. The toll-free numbers to file oral grievances and appeals
5. The Enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing and that if the Contractor's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits

E. Provider Credentialing and Recredentialing

Contractor must comply with the requirements of MCL 500.3528 regarding the credentialing and re-credentialing of providers within the Contractor's network, including, but not limited to the requirements specified in this Section.

1. Contractor must have written credentialing and recredentialing policies and procedures that do the following:
    a. Ensure quality of care
    b. Ensure that all providers rendering services to Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract
    c. Verify that the provider is not debarred or suspended by any State or federal agency
    d. Require the provider to disclose criminal convictions related to federal health care programs
    e. Review the provider's employees to ensure that these employees are not debarred or suspended by any state or federal agency
    f. Require the provider's employees to disclose criminal convictions related to federal health care programs
2. Recredentialing
    a. Contractor must recredential providers at least every three years
    b. Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state
    c. Contractor must maintain written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards

F. Payment to Providers

1. Timely Payments

    Contractor must make timely payments to all providers for covered services rendered to Enrollees as required by MCL 400.111i and in compliance with established MDHHS performance standards
    a. Upon request from MDHHS, the Contractor must develop programs for improving access, quality, and performance with providers. Such programs must include MDHHS in the design methodology, data collection, and evaluation.
    b. Contractor must make all payments to both network and out-of-network providers.
    c. Contractor must not be responsible for any payments owed to providers for services rendered prior to a beneficiary's effective enrollment date with the Contractor.
    d. Contractor is responsible for annual IRS form 1099, Reporting of Provider Earnings, and must make all collected data available to MDHHS and, upon request, to CMS.
    e. Contractor must develop programs to facilitate outreach, education and prevention services with both network and out-of-network providers.
    f. Contractors must provide an annual summary of the outreach, education, and prevention services with the Annual Report due on March 1 of each year.
2. Electronic Billing Capacity
    a. Contractor must meet the HIPAA and MDHHS guidelines and requirements for electronic billing capacity and may require its providers to meet the same standard as a condition for payment.
    b. Contractor must ensure providers bill the Contractor using the same format and coding instructions required for the Medicaid FFS programs according to Medicaid Policy.

c. Contractor must not require providers to complete additional fields on the electronic forms not specified in Medicaid FFS Policy.
d. Contractor may require additional documentation, such as medical records, to justify the level of care provided.
e. Contractors may require prior authorization for services for which the Medicaid FFS program does not require prior authorization except where prohibited by other sections of this Contract or Medicaid policy.
f. Contractor must maintain the completeness and accuracy of their websites regarding this information.

3. Post-Payment Review
   a. Contractor must utilize a post-payment review methodology to assure claims have been paid appropriately.
   b. Contractor must complete post-payment reviews for individuals retroactively disenrolled by MDHHS within 90 days of the date MDHHS notifies the Contractor of the retroactive disenrollment.
   c. Contractor must complete the recoupments from providers within 90 days of identifying the claims to be recouped.
   d. Contractor must not recoup money from providers for individuals retroactively disenrolled by MDHHS more than 180 days from the date that MDHHS notified the Contractor of the retroactive disenrollment.
4. Payment Resolution Process
   a. Contractor must develop and maintain an effective provider appeal process to promptly resolve provider billing disputes and other issues.
   b. Contractor must cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.
5. Arbitration/Rapid Dispute Resolution.
   a. Contractor must comply with the provisions of the Hospital Access Agreement.
   b. To resolve claim disputes with non-contracted hospital providers, the Contractor 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.
   c. When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, the Contractor is required to participate in a binding arbitration process. Providers must exhaust the Contractor's internal provider appeal process before requesting arbitration.
   d. MDHHS 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.
   e. 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 apportioned.
6. Enrollee Liability for Payment
   The Enrollee must not be held liable by Contractor or Contractor's providers for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR 438.116 (i.e., prohibition on balance billing the Enrollee):
   a. Debts of the Contractor, in case of insolvency
   b. Covered services under this Contract provided to the Enrollee for which MDHHS did not pay the Contractor

c. Covered services provided to the Enrollee for which MDHHS or the Contractor does not pay the provider due to contractual, referral or other arrangement
d. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly

7. Hospital Payments
   a. Contractor must pay out-of-network hospitals for all emergency and authorized covered services provided outside of the established network.
      i. Out-of-network hospital claims must be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid providers.
      ii. Hospital payments must include payment for the DRG (as defined in the Medicaid Institutional Provider Chapter) outliers, as applicable, and capital costs at the per-discharge rate.
      iii. Hospital payments must include the applicable hospital reimbursement (e.g. Graduate Medical Education) in the amount and on the schedule defined by MDHHS.
   b. Upon request from MDHHS, Contractor must develop programs for improving access, quality, and performance with both network and out-of-network hospitals in collaboration with MDHHS in the design methodology, data collection, and evaluation and make all payments to both network and out-of-network hospitals defined by the methodology jointly developed by the Contractor and MDHHS.
8. Family Centered Medical Home
   Contractors must make the following per member per month payments to contracted primary care providers who serve CSHCS Enrollees:
   a. $4 to each primary care provider serving a TANF CSHCS Enrollee
   b. $8 to each primary care provider serving an ABAD CSHCS Enrollee
9. Fee Schedule for Primary Care Practitioner Services
   Contractor must provide increased payments to eligible primary care providers rendering specific primary care services to Enrollees. Refer to Medicaid Policy for allowable codes.

XV. Management Information Systems

A. Management Information System (MIS) Capabilities
Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by MDHHS. Contractor must develop, implement and maintain policies and procedures that describe how the Contractor will comply with the requirements of this section. The information system must have the capability for:

1. Collecting data on Enrollee demographics and special population characteristics on services provided to Enrollees as specified by MDHHS through an encounter data system
2. Supporting provider payments and data reporting between the Contractor and MDHHS
3. Controlling, processing, and paying providers for services rendered to Enrollees
4. Collecting service-specific procedures and diagnosis data, collecting price-specific procedures or encounters, and maintaining detailed records of remittances to providers
5. Supporting all Contractor operations, including, but not limited to, the following:

a. Member enrollment, disenrollment, and capitation payments, including the capability of reconciling enrollment and capitation payments received
b. Utilization
c. Case management
d. Provider enrollment
e. Third party liability activity
f. Claims payment
g. Grievance and appeal tracking, including the ability to stratify grievance and appeal by population and track separately (e.g. CSHCS Enrollees)

6. Collecting income, group composition and FPL information for HMP Enrollees
7. Collecting and tracking Enrollee-specific Health Risk Assessment information and providing the information to MDHHS in the specified format, for HMP Enrollees
8. Collecting and tracking Enrollee-specific healthy behavior and goal information for HMP Enrollees and providing information to MDHHS in the specified format

B. Enrollment and Payment Files

MDHHS must provide HIPAA-compliant daily and monthly enrollment files to the Contractor via the Data Exchange Gateway (DEG)

1. Contractor's MIS must have the capability to utilize the HIPAA-compliant enrollment files to update each Enrollee's status on the MIS including Enrollee income, group composition and federal poverty level information for HMP Enrollees.
2. Contractor must load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's vendors (e.g., pharmacy, vision, behavioral health, DME) on or before the first of the month so that Enrollees have access to services.
3. Contractor must reconcile the daily and monthly (4976) enrollment files to the monthly payment file within 30 days of the end of each month.
4. Contractor must ensure that MIS support staff have sufficient training and experience to manage files MDHHS sends to the Contractor via the DEG.

C. Data Accuracy

1. Contractors must ensure all encounter data is complete and accurate for the purposes of rate calculations and quality and utilization management
2. Contractor must ensure data received from providers is accurate and complete by:
   a. Verifying the accuracy and timeliness of the data
   b. Screening the data for completeness, logic and consistency
   c. Collecting service information in standardized formats
   d. Identifying and tracking fraud, waste and abuse

D. Automated Contact Tracking System

Contractor must utilize the MDHHS Automated Contact Tracking System to submit the following requests:

1. Disenrollment requests for out of area Enrollees who appear in the wrong county on the Contractor's enrollment file
2. Requests for newborn enrollment for out-of-state births or births for which MDHHS does not notify the Contractor of the newborn's enrollment within two months of the birth
3. Maternity Case Rate (MCR) Invoice Generation request for births for which the Contractor has not received an MCR payment within three months of the birth
4. Other administrative requests specified by MDHHS

E. Provider Network File (4275)

1. Provider network files are used by the Enrollment Broker to convey information to beneficiaries on available Contractors and network providers for each Contractor.
2. MDHHS utilizes the 4275 to ensure the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation.

3. Contractor must submit provider files that contain a complete and accurate description of the provider network available to Enrollees according to the specifications and format delineated by MDHHS to the MDHHS enrollment services contractor.
4. The 4275 file must contain all contracted providers.
5. Contractor must submit a provider file that passes all MDHHS quality edits to the MDHHS enrollment services contractor at least once per month and more frequently if necessary to ensure changes in the Contractor's provider network are reflected in the provider file in a timely manner.

F. PCP Submission File (5284)

1. Contractor must submit 5284 files containing PCP additions, changes or deletions at least once per month or weekly as required by XIII-B (7)
2. Contractor must submit the addition, change or deletions within 30 days of the PCP assignment or change.
3. Contractor must submit a complete file showing all PCP assignments when requested by MDHHS.

XVI. Health Information Exchange/Health Information Technology

Contractor must support MDHHS initiatives to increase the use of Health Information Exchange and Health Information Technology (HIE/HIT) to improve care management and coordination; reduce fraud, waste and abuse; and improve communication between systems of care.

A. Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

MDHHS has established rules and guidelines to advance the adoption and meaningful use of certified EHR technology through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH).

1. Contractor must comply with MDHHS performance programs designed to advance provider adoption and meaningful use of certified EHR.
2. Contractor must assist MDHHS in statewide efforts to target high-volume Medicaid providers eligible for the EHR incentive payments.
3. Contractors are encouraged to align provider incentives with meaningful use objectives and measures and clinical quality measure reporting.
4. Contractor must promote the EHR Incentive Programs as part of regular provider communications.
5. Contractor must electronically exchange eligibility and claim information with providers to promote the use of EHR.

B. Michigan Health Information Network

Contractors must join the Michigan Health Information Network (MiHIN) Shared Services and engage and incentivize their provider network to increase the number and percentage of network providers that are members of Health Information Exchange Qualified Organization (HIE QO).

1. Contractor must, by the end of Contract Year One, join the Michigan Health Information Network (MiHIN) Shared Services as a Qualified Organization.
2. Contractor must, by the end of Contract Year One, report to MDHHS the number and percentage of contracted providers connected to a Health Information Exchange Qualified Organization (HIE QO).
3. Contractor must, by the end of Contract Year Two, submit to MDHHS a plan to offer incentives for providers to join a HIE QO.
4. Contractor incentive plan must prioritize:
    a. Provider capability to, at a minimum, receive admission, discharge and transfer (ADT) messages

b. Provider participation in the statewide Active Care Relationship Service (ACRS) thereby enabling access to the Common Key Service
c. Provider participation in the statewide Medication Reconciliation MiHIN Use Case for the purpose of sharing patient medication information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities
d. Provider adoption of e-prescribing and e-portals in accordance with national and State laws and Office of the National Coordinator for Health Information Technology (ONC) regulations and standards for meaningful use

C. Electronic Exchange of Client-Level Information
1. Contractor must implement and maintain an electronic data system, by which providers and other entities can send and receive client-level information for the purpose of care management and coordination.
2. The electronic data system must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations.
3. Contractor must ensure LHDs and CMDS clinics that provide and coordinate services for CSHCS Enrollees have the ability to exchange real-time client-level information for the purpose of care management and coordination.
4. Contractor must ensure PIHPs that provide behavioral health services to Enrollees have the ability to exchange real-time client-level information for the purpose of care management and coordination and reporting quality metrics.

XVII. Observance of State and Federal Laws and Regulations

A. General
1. Contractor must comply with all State and federal laws, statutes, regulations, and administrative procedures and implement any necessary changes in policies and procedures as required by MDHHS.
2. Federal regulations governing contracts with risk-based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract.
3. Centers for Medicare & Medicaid Services (CMS) has granted MDHHS a waiver under Section 1915(b)(1)(2) of the Social Security Act, granting the State a waiver of section 1902 (a)(23) of the Social Security Act. Under this waiver, beneficiaries will be enrolled with a Contractor in the county of their residence. All health care for Enrollees will be arranged for or administered by the Contractor. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this Contract.

B. Fiscal Soundness of the Risk-Based Contractor
Federal regulations (42 CFR 438.116) require that the risk-based Contractors maintain a fiscally solvent operation.
1. Contractor must comply with all HMO statutory requirements for fiscal soundness and MDHHS will evaluate the Contractor's financial soundness based upon the thresholds established in Appendix 2 of this Contract.
2. If the Contractor does not maintain the minimum statutory financial requirements, MDHHS will apply remedies and sanctions as specified in this Contract, including termination of the Contract.
3. Contractor must maintain financial records for its Medicaid activities separate from other financial records.

C. Accreditation/Certification Requirements
1. Contractor must hold and maintain accreditation as a managed care organization by the NCQA or URAC Accreditation for Health Plans. Any Contractor not currently

accredited in the State of Michigan prior to 1/1/2016 must obtain accreditation from NCQA or URAC within one year of contract start date (see XI-K (2)(m)).

2. Contractor must be incorporated within the State of Michigan and have a Certificate of Authority to operate as a Health Maintenance Organization (HMO) in the State of Michigan in accordance with MCL 500.3505 (see XI-K (2)(n)).

D. Compliance with False Claims Acts

Contractor must comply with all applicable provisions of the federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and State laws specifically include, but are not limited to, the following:

1. Establish and disseminate written policies for employees of the entity (including managing employees) and any contractor or agent of the entity regarding the detection and prevention of waste, fraud, and abuse.
2. The written policies must include detailed information about the federal False Claim Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act.
3. The written policies must specify the rights of employees to be protected as whistleblowers.
4. The written policies must also be adopted by the Contractor's contractors or agents. A "contractor" or "agent" includes any contractor, Subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.
5. If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees regarding detection and prevention of fraud, waste and abuse including an explanation of the false claims acts and of the rights of employees to be protected as whistleblowers.

E. Protection of Enrollees against Liability for Payment and Balanced Billing

1. Contractors must not balance-bill the Enrollee pursuant to Section 1932(b)(6) of the Social Security Act protecting Enrollees from certain payment liabilities. Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to providers in the case of services provided to an individual enrolled with a Contractor that charges a rate in excess of the rate permitted under the organization's Contract.

F. Disclosure of Physician Incentive Plan

1. Contractor must disclose to MDHHS, upon request, the information on their provider incentive plans listed in 42 CFR 422.208 and 422.210, as required in 42 CFR 438.6(h).
2. Contractor's incentive plans must meet the requirements of 42 CFR 422.208-422.210 when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903(s) of the Social Security Act.
3. Upon request, the Contractor must provide the information on its physician incentive plans listed in 42 CFR 422.208 and 422.210 to any Enrollee.

G. Third Party Resource Requirements

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of an Enrollee's health care coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to be made whole.

1. Contractors may identify and recover all sources of third party funds based on industry standards.

2. Contractor may retain all such collections. If third party resources are available, the Contractor is not required to pay the provider first and then recover money from the third party; however, the Contractor may elect to do so.
3. Contractor must follow Medicaid Policy regarding TPL.
4. Contractor must report third party collections through encounter data submission and in aggregate as required by MDHHS.
5. Contractor must collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D.
6. MDHHS must provide the Contractor with a list of known third party resources for its Enrollees. The listing will be produced monthly and contain information made available to MDHHS at the time of eligibility determination or re-determination.
7. If Contractor denies a claim due to third party resources (other insurance), the Contractor must provide the other insurance carrier ID, if known, to the billing provider.
8. When an Enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any Contractor. Contractor must make the Enrollee whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the Enrollee such as coinsurance and deductible.

H. Marketing

Contractor may promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of an entire city, an entire county, or larger population segment in the Contractor's approved service area.

1. Contractor must comply with the marketing, branding, incentive, and other relevant guidelines established by MDHHS.
2. Contractor may provide incentives, consistent with State law, to Enrollees that encourage healthy behavior and practices.
3. Contractor must secure MDHHS approval for all marketing materials prior to implementation.
    a. Upon receipt by MDHHS of a complete request for approval that proposes allowed marketing practices and locations, MDHHS will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. The review clock will be tolled while the Contractor revises materials for re-submission.
    b. Contractor may repeatedly use marketing materials previously approved by MDHHS; Contractor must notify MDHHS of intent to repeat marketing materials/initiative and attest it is identical to the MDHHS-approved marketing prior to implementation.
4. Contractor must not provide inducements to beneficiaries or current Enrollees through which compensation, reward, or supplementary benefits or services are offered to enroll or to remain enrolled with the Contractor.
5. Direct marketing to individual beneficiaries not enrolled with the Contractor is prohibited. For purposes of oral or written marketing material, and contact initiated by the beneficiary, the Contractor must adhere to the following guidelines:
    a. Contractor may only provide factual information about the Contractor's services and contracted providers.
    b. If the Enrollee requests information about services, the Contractor must inform the Enrollee that all MHPs are required, at a minimum, to provide the same services as the Medicaid FFS.
    c. Contractor must not make comparisons with other Contractors.
    d. Contractor must not discuss enrollment, disenrollment, or Medicaid eligibility; the Contractor must refer all such inquiries to the State's enrollment broker.

6. Examples of Allowed Marketing Locations and Practices Directed at the General Population
    a. Newspaper articles
    b. Newspaper advertisements
    c. Magazine advertisements
    d. Signs
    e. Billboards
    f. Pamphlets
    g. Brochures
    h. Radio advertisements
    i. Television advertisements
    j. Online advertising
    k. Social media
    l. Non-capitated plan sponsored events
    m. Public transportation (e.g. buses, taxicabs)
    n. Mailings to the general population
    o. Health Fairs for Enrollees
    p. Malls or commercial retail establishment
    q. Community centers, schools and daycare centers
    r. Churches
7. Prohibited Marketing Locations/Practices that Target Individual Beneficiaries:
    a. Local DHS offices
    b. Provider offices, clinics, including but not limited to, WIC clinics, with the exception of window decals that have been approved by MDHHS
    c. Hospitals
    d. Check cashing establishments
    e. Door-to-door marketing
    f. Telemarketing
    g. Direct mail targeting individual Medicaid Beneficiaries not currently enrolled in the Contractor's plan
    h. The prohibition of marketing in provider offices includes, but is not limited to, written materials distributed in the providers' office.
    i. Contractor must not assist providers in developing marketing materials designed to induce beneficiaries to enroll or to remain enrolled with the Contractor or not disenroll from another Contractor
    j. Contractor may provide decals to participating providers which can include the health plan name and logo. These decals may be displayed in the provider office to show participation with the health plan. All decals must be approved by MDHHS prior to distribution to providers.

I. Health Fairs

1. Contractor may participate in health fairs that meet the following guidelines.
2. Organized by an entity other than an MHP, such as, a local health department, a community agency, or a provider, for Enrollees and the general public.
3. Conducted in a public setting, such as a mall, a church, or a local health department. If the health fair is held in a provider office, all patients of the provider must be invited to attend. Health screenings may be provided as long as all participants in the health fair have the opportunity to be screened.
4. Beneficiary attendance is voluntary; no inducements other than incentives approved by MDHHS under this Contract may be used to encourage or require participation.
5. Advertisement of the health fair must be directed at the general population, be approved by MDHHS, and comply with all other applicable requirements. A Contractor's name may be used in advertisements of the health fair only if MDHHS has approved the advertisement.

6. The purpose of the health fair must be to provide health education and/or promotional information or material, including information about managed care in general.
7. No direct information may be given regarding enrollment, disenrollment or Medicaid eligibility. If a beneficiary requests such information during the health fair, the Contractor must instruct the beneficiary to contact the State's enrollment broker.
8. No comparisons may be made between Contractors, other than by using material produced by a State Agency, including, but not limited to, the MDHHS Quality Check-Up.

J. Confidentiality

1. Contractor must comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); this includes the designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.
2. All Enrollee information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by the Contractor from unauthorized disclosure.
3. Contractor must provide safeguards that restrict the use or disclosure of information concerning Enrollees to purposes directly connected with its administration of the Contract.
4. Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services.

K. Medical Records

1. Contractor must ensure its providers maintain medical records of all medical services received by the Enrollee. The medical record must include, at a minimum:
    a. A record of outpatient and emergency care
    b. Specialist referrals
    c. Ancillary care
    d. Diagnostic test findings including all laboratory and radiology,
    e. Prescriptions for medications,
    f. Inpatient discharge summaries,
    g. Histories and physicals,
    h. Immunization records,
    i. And other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided
2. Contractor's medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment.
    a. Medical records must be signed and dates
    b. All medical records must be retained for at least seven years
3. Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.
4. Contractor must have written plans for providing training and evaluating providers' compliance with the recognized medical records standards
5. Contractor must have written policies and procedures to maintain the confidentiality of all medical records.
6. Contractor must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information.

7. MDHHS and/or CMS must be given prompt access to all Enrollees' medical records – without written approval from an Enrollee – before requesting an Enrollee's medical record.
8. When an Enrollee changes PCP, the former PCP must forward the Enrollee's medical records or copies of medical records to the new PCP within 10 working days from receipt of a written request.

L. Advanced Directives Compliance

1. Contractor must comply with all provisions for advance directives (described in 42 CFR 422.128) as required in 42 CFR 438.6.
2. Contractor must have in effect, written policies and procedures for the use and handling of advance directives written for any adult individual receiving medical care by or through the Contractor. The policies and procedures must include at least the following provisions:
    a. The Enrollee's right to have and exercise advance directives under the law of the State of Michigan, (MCL 700.5506-700.5512 and MCL 333.1051-333.1064)
    b. Changes to laws pertaining to advanced directives must be updated in the policies no later than 90 days after the changes occur, if applicable
    c. Contractor's procedures for respecting advanced directives rights, including any limitations if applicable

XVIII. Program Integrity

The MDHHS, Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Michigan Medicaid Health Plans

A. General

1. Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan.
2. Contractor's arrangements or procedures must include the following as defined in 42 CFR 438.608:
    a. Written policies and procedures that describes how the Contractor will comply with federal and State fraud, waste, and abuse standards
    b. The designation of a compliance officer and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the Contractor's employees
    c. Effective training and education for the compliance officer and the Contractor's employees
    d. Provisions for internal monitoring and auditing
    e. Provisions for prompt response to detected offenses and for the development of corrective action initiatives
    f. Documentation of the Contractor's enforcement of federal and State fraud and abuse standards
    g. Provision of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste, or abuse for both the Contractor and the MDHHS-OIG to their employees, members, and providers annually. Contractor must indicate that reporting of fraud, waste, or abuse may be made anonymously.

B. Explanation of Benefits

1. Contractor must provide monthly Explanation of Benefits (EOBs) to a minimum of 5% of the Enrollees receiving services.
2. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by MDHHS.

C. Reporting Fraud, Waste or Abuse

1. Contractor must report/refer all (employee, providers and members) suspicion of fraud, waste, or abuse to MDHHS-OIG via email (MDHHS-OIG@michigan.gov).

2. Documents containing protected health information or protected personal information that are submitted with reports/referrals must be zipped and encrypted with passwords. The report/referral must include, at minimum the items listed as follows:
    a. Subject (name, address, phone number, member Medicaid identification number, provider NPI and type, and any other identifying information)
    b. Source/origination of the complaint
    c. Date reported/referred to MDHHS-OIG
    d. Nature of the complaint including, but not limited to:
        i. Type of service
        ii. Factual explanation of the suspected fraud/abuse
        iii. Medicaid statutes, rules, regulations, or policies violated
        iv. Dates of suspected fraud or abuse
    e. Approximate range of dollars involved
    f. Amount paid on behalf of a member or to a provider during the past 3 years or during the period of the suspected fraud or abuse, whichever is greater
    g. Encounter claims for the amount paid on behalf of a member or to a provider during the past 3 years or during the period of the suspected fraud or abuse, whichever is greater
    h. All communications between the Contractor and member or provider concerning the suspected fraud or abuse
    i. Contact information for Contractor staff person with the most knowledge relating to the report/referral and with the password for the zipped/encrypted documents
    j. Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred
    k. Any and all documentation, data, or records obtained, reviewed, or relied on by the Contractor leading to the suspicion of fraud or abuse including but not limited to:
        i. Beneficiary/Patient files
        ii. Audit reports and findings
        iii. Medical necessity reviews and the reviewing personnel

D. Prepayment Review

Contractor must disclose to MDHHS-OIG via email (MDHHS-OIG@michigan.gov) the names and NPI numbers of providers the Contractor intends to place on prepayment review before doing so. Contractors must include in such disclosure the following:

1. Subject (name, address, phone number, provider NPI and type, and any other identifying information)
2. Date the Contractor plans to place the subject on prepayment review
3. The reason for the prepayment review
4. The data or information relied on in placing the provider on prepayment review

E. Provider Investigations

1. Contractor must inform MDHHS-OIG of actions taken to investigate or resolve the reported suspicion, knowledge, or action.
2. Contractor must cooperate fully in any investigation by MDHHS-OIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

F. Disclosure of Information

1. Contractor is permitted to disclose protected health information to MDHHS-OIG or the Department of Attorney General without first obtaining authorization from the Enrollee to disclose such information. OIG and the Department of Attorney General must ensure that such disclosures meet the requirements for disclosures

made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.501.

G. Overpayments

1. If the Contractor identifies an improper payment prior to the MDHHS-OIG, Contractor is to recover the overpayment and report the overpayment on their quarterly program integrity submission.
2. If MDHHS-OIG identifies an improper payment prior to the Contractor, the State will explore options up to and including recovering the overpayment from the Contractor.

H. Quarterly Submissions

1. Contractor must provide the numbers and details of program integrity activities performed quarterly. These activities fall into five main categories: tips/grievances, data mining/algorithms, audits, overpayments, and provider disenrollments.
2. Contractor must provide the number of beneficiaries receiving services each quarter and the number of EOBs sent out to beneficiaries each quarter.
3. Activities performed January through March must be reported by May 15; activities performed April through June must be reported by August 15; activities performed July through September must be reported by November 15; and activities performed October through December must be reported by February 15.
4. Program integrity activities must be reported to MDHHS-OIG in the format developed by the State. A Contractor not initiating any data mining activities or performing any audits within a given quarter will receive a score of fail for that compliance review quarter.

I. Health Plan and Provider Enrollment, Screening, and Disclosure Requirements (42 CFR 438.610 and 42 CFR 455 Subpart B)

1. Contractor may not knowingly have a director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the entity's equity who is currently debarred or suspended by any state or federal agency.
2. Contractor is prohibited from having a contractual, employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State.
3. MDHHS may refuse to enter into or renew a contract with Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. Additionally, MDHHS may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under this section.
4. All required disclosures under this subsection must be made to MDHHS or CMS in the format developed by the State. Failure to provide required information may lead to sanctions including withholding of capitation payment. Because federal financial participation is not available for entities that do not comply with disclosures, MDHHS may withhold capitation from the Contractor for services provided during the period beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied.

J. Ownership and Control of Contractor

1. Contractors must disclose the following information for any and all persons (individual or corporation) with an ownership or control interest in the Contractor:
    a. Name and Address. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

b. The date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor.
c. Tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by the Contractor in which the Contractor has a 5 percent or more interest.
d. The name, address, date of birth, the Social Security Number of managing employee of the Contractor. For purposes of this subsection, managing employees are the following: President/Chief Executive Officer, Chief Operating Officer, Chief Financial Officer and Chief of Management Information Systems.
e. Information regarding relationships to others with ownership or control interest. Contractor must report if the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
f. Information regarding related organizations. Contractor must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which the Contractor has an ownership or control interest.

2. Disclosures for Ownership and Control of the Contractor must be made to MDHHS at the following times:
   a. Proposal submission in accordance with the State's procurement process.
   b. Contract execution
   c. Contract extension
   d. Within 35 days of a change in ownership of the Contractor
3. Reporting of Business Transactions of Contractor – Within 35 days of request by MDHHS or CMS, the Contractor must provide information related to specific business transactions which include the following:
   a. The ownership of any subcontractor as defined in Section 2.3 with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
   b. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, as defined in Section 2.3, during the 5-year period ending on the date of the request.

K. Providers not Enrolled/Registered in MDHHS Provider Enrollment System

1. Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. An Enrollee may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds may be used. All providers must be properly credentialed to perform services.
2. All contracted providers must either be enrolled/registered with the Michigan Medicaid Program OR be properly vetted by the Contractor in accordance with 42 CFR 438.610 at least monthly.
3. Contractor must collect, at minimum, names, dates of birth, social security numbers, home addresses, etc. for every provider, director, officer, partner, agent, employee, and anyone with beneficial ownership of more than 5% of the provider's equity. Contractor must validate that none of these people/entities are debarred

from receiving federal or state funds. The files/database that must be checked include:

a. Social Security Administration's Death Master File
b. National Plan and Provider Enumeration System (NPPES)
c. List of Excluded Individuals/Entities (LEIE)
d. System for Award Management (SAM) at www.sam.gov
e. Medicare Exclusion Database (MED)
f. Any other databases as the Secretary of HHS may prescribe
g. Michigan Medicaid Sanctioned Provider List
h. Licensing and Regulatory Affairs (LARA) Disciplinary Action Request (DAR) as updates are published

4. Contractor must also collect information related to criminal convictions of Federal healthcare programs. Within 20 working days of receipt of the disclosure of an out of network/non-contractor provider, the Contractor must notify the federal Inspector General of HHS. And, the Contractor must promptly notify the federal Inspector General of HHS and MDHHS-OIG of any action it takes in respect to its provider's enrollment.
5. Contractor must report within 20 working days to the Inspector General of HHS and MDHHS any adverse actions taken at any time on provider applications due to fraud, quality or integrity issues as outlined under 42 CFR § 1002.3.
6. Contractor must have policies and procedures in place which specify that adverse actions taken during provider enrollment or at any time action is taken to limit the ability of an individual to participate in the plan for reasons of fraud, quality or integrity as found under 42 CFR § 1002.3 (b)(2) and 42 CFR § 1002.3 (b)(3) must be reported within 20 working days of taking action to the Inspector General of HHS and MDHHS.

1.2 Readiness Reviews

Contractors must complete readiness reviews at the discretion of MDHHS. Contractors must be ready to perform all contractual responsibilities on or before January 1, 2016. Readiness reviews will include, but not be limited to, business-to-business testing for file transfers, member material review and member services readiness.

2.0 Personnel, Organizational Structure, Governing Body and Subcontractors

2.1 Personnel, Organizational Structure, and Governing Body

I. Personnel

The Contractor must appoint individuals who will be directly responsible for the day-to-day operations of the Contract ("Personnel"). Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 48 hours.

A. Administrative Personnel Requirements

1. Contractor must employ or contract with sufficient administrative staff to comply with all program standards. Contractor must specifically staff positions a-k. Below are the identified personnel for those positions:

a. Executive Director/Chief Executive Officer (CEO) – Dennis Mouras
b. Medical Director – Brian Kennedy, MD
c. Quality Improvement Director – Mary Ellen Gies
d. Chief Financial Officer (CFO) – Carol Gothard
e. Management Information System Director – Cybele Kanin
f. Compliance Officer – Michael Parr
g. Member Services Director – Gary Rathbun
h. Provider Services Director – Lisa Gray
i. Grievance and Appeals Coordinator – Devon Collins
j. Medicaid Liaison – Lisa Gray
k. MIS Liaison – Sharon Theut /Rose Myers

2. Contractor must ensure that all staff has appropriate training, education, experience, licensure as appropriate and liability coverage to fulfill the requirements of the positions.
3. Resumes for all administrative personnel listed above in (A) (1) (a-k) of this section must be provided to MDHHS upon request. Resumes must include detailed, chronological work experience.

B. Executive Personnel

1. Contractor must inform MDHHS in writing within seven days of vacancies or staffing changes for the personnel listed in (A) (1) (a-f) of this section.
2. Contractor must inform MDHHS in writing within 14 days of vacancies or staffing changes for the personnel listed in (A) (1) (g-k).
3. Contractor must fill vacancies for the personnel listed in (A) (1) (a-f) of this section with qualified persons within six months of the vacancy unless an extension is granted by MDHHS.

C. Administrative Personnel Responsibilities

1. Executive Director/Chief Executive Officer (CEO)
   a. Full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract.
   b. Oversight of budget and accounting systems.
   c. Responsibility to the governing body for daily operations.
2. Medical Director
   a. Michigan-licensed physician (MD or DO).
   b. Responsible for all major clinical program components of the Contractor.
   c. Responsibility to review medical care provided to Enrollees and medical aspects of provider contracts.
   d. Ensure timely medical decisions, including after-hours consultation as needed.
   e. Management of the Contractor's Quality Assessment and Performance Improvement Program.
   f. Must ensure compliance with State and local reporting laws on communicable diseases, child abuse, and neglect.
3. Quality Improvement and Utilization Director
   a. Full-time administrator who possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be any of the following:
      i. Michigan licensed physician.
      ii. Michigan licensed registered nurse.
      iii. Certified professional in health care quality.
      iv. Other licensed clinician as approved by MDHHS.
      v. Other professional possessing appropriate credentials as approved by MDHHS.
   b. Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.
4. Chief Financial Officer
   Full-time administrator responsible for overseeing the budget and accounting systems.

5. Management Information System Director
   Full-time administrator who oversees and maintains the data management system to ensure the MIS is capable of valid data collection and processing, timely and accurate reporting, and correct claims payments.
6. Compliance Officer
   Full-time administrator to oversee the Contractor's compliance plan and to verify that fraud and abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.
7. Member Services Director
   a. Coordination of communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate.
   b. Ensure sufficient member services staff to enable Enrollees to receive prompt resolution of their problems or inquiries.
8. Provider Services Director
   a. Coordination of communications with Subcontractors and other providers.
   b. Ensure sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.
9. Grievance/Appeal Coordinator
   Coordination, management, and adjudication of Enrollee and provider grievances
10. Security Officer
    a. Development and implementation of security policies and procedures outlined in 45 CFR 164.
    b. Designated as the individual to receive complaints pursuant to security breaches in the Contractor's or State's policies and procedures.
11. Privacy Officer
    a. Development and implementation of privacy policies and procedures outlined in 45 CFR 164.
    b. Designated as the individual to receive complaints pursuant to breaches of the Contractor's privacy policies and procedures.
12. Designated Liaisons
    a. General management (Medicaid) liaison.
    b. MIS liaison.
13. Support/Administrative Staff
    Contractor must have adequate clerical and support staff to ensure that the Contractor's operation functions in accordance with all Contract requirements.

II. Organizational Structure

A. Contractor Administrative Linkages
   Contractor's management approach and organizational structure must ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, grievance/appeal review, and management information systems.

B. Contractor Administrative Practices
   Contractor must be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. Contractor must employ senior level managers with experience and expertise in health care management and must employ or contract with skilled clinicians for medical management activities.

C. Contractor Organizational Chart
   Contractor must provide a copy of the current organizational chart with reporting structures, names, and positions to MDHHS upon request.

D. Financial Interest for Contractor Employees
   Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its provider network or in the conduct of the Contractor's affairs. Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been

suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes managing employees, all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

E. Disclosure of Financial Interest for Contractor Employees
Contractor must provide to MDHHS, upon request, a notarized and signed disclosure statement fully disclosing the nature and extent of any contracts or arrangements between the Contractor or a provider or other person concerning any financial relationship with the Contractor and any one of the following:
1. Providers – all contracted providers
2. Provider employees – directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity
3. Contractor employees – director, officer, partner, managing employee, or persons with beneficial ownership of 5% or more of the entity's equity

F. Contractor must notify MDHHS in writing of a substantial change in the facts set forth in the statement within 30 days of the date of the change. Information required to be disclosed in this section must also be available to the Department of Attorney General, Health Care Fraud Division.

III. Governing Body

A. Contractor Governing Body
Contractor must have a governing body to ensure adoption and implementation of written policies governing the operation of the Contractor.

B. Governing Body Chair
The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body.

C. Governing Body Meetings
The governing body must meet at least quarterly, and must keep a permanent record of all proceedings available to MDHHS and/or CMS upon request.

D. Governing Body Membership
A minimum of 1/3 of the membership of the governing body must consist of adult Enrollees who are not compensated officers, employees, stockholders who own 5% or more of the equity with the Contractor, or other individuals responsible for the conduct of, or financially interested in, the Contractor's affairs.

E. Governing Body Procedures
Contractor must have written policies and procedures for governing body elections detailing, at a minimum, the following:
1. How Enrollee board members will be elected
2. The length of the term for board members
3. Filling of vacancies
4. Notice to Enrollees

F. Enrollee Board Members
Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan.

2.2 Disclosure of Subcontractors

If the Contractor intends to change Subcontractors, the Contractor must complete Appendix 12 – Subcontractor Template and submit to the MDHHS Program Manager.

2.3 Subcontractor Classifications and Flow-down

I. Subcontractor Classifications

A. Health Benefit Managers
Health Benefit Managers (HBMs) are entities that arrange for the provision of health services covered under this Contract, with the exclusion of transportation.

1. Health Benefit Managers can include, but are not limited to;
    a. Pharmacy Benefit Managers,
    b. Behavioral Health Benefit Managers, and
    c. Vision Benefit Managers
    d. Community Health Worker Organizations
2. Contractor must notify MDHHS of a new Health Benefit Manager 30 days prior to the effective date of the contract with the Health Benefit Manager.
3. MDHHS reserves the right to approve or reject the Contractor's proposed use of a Health Benefit Manager.

B. Administrative Subcontractors
Administrative Subcontractors are entities that perform administrative functions required by this Contract such as claims payment, delegated credentialing, and card production and mailing services.

1. Administrative Subcontractors are classified by function.
    a. Type A Administrative Subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or another functions involving payment decisions.
    b. Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization management, or case-management.
    c. Type C Administrative Subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical decisions. This type of administrative Subcontractor includes but is not limited to identification card production and mailing services.
2. The Contractor must notify MDHHS of any new Administrative Subcontractors within 21 days of the effective date of the contract with the Administrative Subcontractor.
3. MDHHS reserves the right to approve or reject Contractor's proposed use of an Administrative Subcontractor.

C. Transportation Subcontractor
Transportation Subcontractors are entities that arrange or arrange and provide transportation services.

1. Transportation Subcontractors are divided into two types, as follows:
    a. Type A: Transportation Benefit Managers subcontract with other entities to provide Enrollees transportation to and from health care services.
    b. Type B: Transportation Providers are entities or agencies that arrange and provide Enrollees transportation to and from health care services (e.g. social or religious agencies).
2. Contractor must notify MDHHS of Type A and Type B Transportation Subcontractors within 30 days of the effective date of the contract with the Subcontractor.
3. MDHHS reserves the right to approve or reject the Contractor's proposed use of any Transportation Subcontractor.

II. Flow-down of Contractor Responsibility

Except where specifically approved in writing by the State on a case-by-case basis, Contractor must flow-down the obligations in Section 2.3 in all of its agreements with any Subcontractors as specified by type of subcontract.

A. Contractor Full Responsibility

1. Contractor has full responsibility for the successful performance and completion of all Contract Requirements as specified in Exhibit A, regardless of whether the Contractor performs the work or subcontracts for the services.

2. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted per Section 2.2 Disclosure of Subcontractors.
3. Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract including the insurance provisions specified in the Standard Contract Terms, as applicable.
4. Contractor is the sole point of contact for the State with regard to all contractual matters under this Contract, including payment of any and all charges for services included in Exhibit A.

B. State Consent to Delegation
Contractor must not delegate any duties under this Contract to a Subcontractor except as specified in Sections 2.2 and 2.3. MDHHS has the right of prior written approval of Heath Benefit Managers and Transportation Subcontractors and to require Contractor to replace any Heath Benefit Managers and Transportation Subcontractors found, in the reasonable judgment of the State, to be unacceptable.

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

D. Cooperation with Third Parties
1. Contractor personnel and the personnel of any Subcontractors must cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel.
2. Contractor must provide to the State's agents and other contractors reasonable access to Contractor's project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and will not interfere or jeopardize the safety or operation of the systems or facilities.
3. State acknowledges that Contractor's time schedule for the Contract is very specific and agrees not to unnecessarily or unreasonably interfere with, delay or otherwise impede Contractor's performance under this Contract with requests for access.

3.0 Project Management

3.1 Meetings

I. Mandatory Administrative Meetings

A. Contractor Representatives
Contractor representative must attend the following meetings:

1. Bimonthly Administrative Issues (bimonthly)
2. Clinical Advisory Committee (quarterly)
3. CEO (bimonthly)
4. Operations (biweekly)

B. Contractor Collaboration
Contractor must attend other meetings as directed by MDHHS for the purpose of performing Contract Requirements, improving workflows, and otherwise collaborating with MDHHS for benefit of Enrollees, Contractors, and the State.

II. Mandatory Stakeholder Meetings
Contractor must facilitate or otherwise ensure all required meetings with entities named/described in this Contract (e.g. meetings with PIHPs, community collaboration meetings) take place as directed at requisite intervals.

3.2 Reporting

I. Data Reporting

A. Uniform Data and Information

1. To measure the Contractor's accomplishments in the areas of access to care, utilization, medical outcomes, Enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the Contractor must provide MDHHS with uniform data and information as specified by MDHHS.
2. Contractor must submit reports as specified in this Section. Any changes in the reporting requirements will be communicated to the Contractor at least 30 days before they are effective unless State or federal law requires otherwise.
3. Contractor must submit all reports according to section 3.2 and provide MDHHS with additional ad hoc information as requested.
4. Contractor must cooperate with MDHHS in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols.
5. Contractor must develop and implement corrective action plans to correct data validity problems as identified by MDHHS.

II. Contractor Reports

A. Annual Report
Contractor must submit an annual consolidated report to include the section described below and following using the instructions and format outlined in Contract Appendix 3.

1. Litigation Report: Contractors must submit an annual litigation report in a format established by MDHHS, providing detail for all civil litigation to which the Contractor, Subcontractor, or the Contractor's insurers or insurance agents are party.
2. Data Certification Report: Contractor's CEO must submit a MDHHS Data Certification form to MDHHS that requires the Contractor to attest to the accuracy, completeness, and truthfulness of any and all data and documents submitted to the State as required by the Contract. When the health plan employs a new CEO, a new MDHHS Data Certification form must be submitted to MDHHS within 15 days of the employment date.
3. EPSDT information: Contractor must provide the following:
   a. List and brief description of member incentives offered to increase member utilization of EPSDT service.
   b. List and brief description of provider incentives offered to increase provider monitoring of/providing EPSDT services
4. Health Plan Profile: Contractor must provide all information requested on the Health Plan Profile form provided by MDHHS and attach all required documents.

5. Financial Reports: The Contractor must submit the Annual NAIC financial statement and all financial reports required by DIFS.
6. Physician Incentive Program (PIP) Reporting: The Contractor must submit the MDHHS PIP Attestation form and PIP Disclosure forms required by MDHHS.
7. Medicaid Provider Directory: The Contractor must provide an electronic copy of the Medicaid Provider Directory that is effective on the date the annual report is submitted to MDHHS.
8. Medicaid Certificate of Coverage: The Contractor must provide a copy of the Medicaid Certificate of Coverage that is approved and effective on the date the annual report is submitted to MDHHS.
9. Medicaid Member Handbook: The Contractor must provide a copy of the Medicaid Member Handbook that is approved and effective on the date the annual report is submitted to MDHHS.

B. Quality Assurance and Performance Improvement Assessment
1. Contractor must perform and document an annual assessment of their QAPI program to include a description of any program completed and all ongoing quality improvement activities for the applicable year, an evaluation of the overall effectiveness of the program, and an annual work plan.
2. MDHHS may also request other reports or improvement plans addressing specific Contract performance issues identified through site visit reviews, EQRs, focused studies, or other monitoring activities conducted by MDHHS.

C. Additional Financial Reports
1. Contractors must meet all HMO financial reporting requirements and provide to MDHHS copies of the HMO financial reports.
2. Contractor must submit the following financial reports in the format required by MDHHS and in the timeframe specified in Appendix 3
   a. Quarterly NAIC financial reports
   b. Annual Management Discussion and Analysis
   c. Annual Audited Financial Statements
3. MDHHS may require monthly financial statements from the Contractor.

D. HEDIS Submission
1. Contractor must annually submit a Medicaid-product HEDIS report according to the most current NCQA specifications and MDHHS timelines.
2. Contractor must contract with an NCQA certified HEDIS vendor and undergo a full audit of their HEDIS reporting process

E. Encounter Data Submission
1. Contractor must utilize National Provider Identifier (NPI) to track services and submit encounter data. The Contractor must submit encounter data containing detail for each patient encounter reflecting services provided by the Contractor.
2. Encounter records will be submitted monthly via electronic media in a HIPAA compliant format as specified by MDHHS.
3. Contractors must populate all fields required by MDHHS including, but not limited to, financial data for all encounters and fields required for the MCO pharmacy rebate. Submitted encounter data will be subject to quality data edits prior to acceptance into MDHHS's data warehouse. The Contractor's data must pass all required data quality edits in order to be accepted into MDHHS's data warehouse. Any data that is not accepted into the MDHHS data warehouse will not be used in any analysis, including but not limited to rate calculations, DRG calculations, and risk score calculations. MDHHS will not allow Contractors to submit incomplete encounter data for inclusion into the MDHHS data warehouse and subsequent calculations.
4. Stored encounter data will be subject to regular and ongoing quality checks as developed by MDHHS. MDHHS will give the Contractor a minimum of 60 days' notice prior to the implementation of new quality data edits; however, MDHHS may

implement informational edits without 60 days' notice. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by MDHHS (see Appendix 4). The Contractor must participate in regular data quality assessments conducted as a component of ongoing encounter data on-site activity.

F. Claims Reporting
Contractor must provide to MDHHS monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by MDHHS

G. Quarterly Grievance and Appeal Report
1. Contractor must track the number and type of grievances and appeals.
2. Appeals information must be summarized by the level at which the grievance or appeal was resolved and reported in the format designated by MDHHS.
3. Contractor must utilize the definition of grievance and appeal specified in this Contract for tracking and reporting grievance and appeals.

H. Healthy Michigan Plan Reporting
Contractor must comply with all the reporting requirements specified in the following:
1. Operational Protocol for MI Health Accounts
2. Operational Protocol for Healthy Behaviors
3. CMS Special Terms and Conditions of the 1115 Waiver Approval
4. 107 P.A. 2013

I. Provider Race/Ethnicity Reporting
Contractor will work with providers and MDHHS to collect and report the race/ethnicity of their contracted providers. Contractor will report the race/ethnicity of contracted providers to MDHHS within the specified timeline.

J. Other Data Sources
MDHHS may develop other data sources and/or measures during the course of the contract term. MDHHS must work with the Contractor to develop data formats and mechanisms for data submission. The Contractor must work with MDHHS to provide data in the format and timeline specified by MDHHS.

III. Release of Report Data

A. Written Approval
Contractor must obtain MDHHS's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its Enrollees other than as required by this Contract, statute or regulations. The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract.

B. Acceptable Use of State Data
Contractor will not use the State's data for any purpose other than providing the Services to Enrollees covered by the Contractor under any Contract or Program, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data.

C. Acceptable Use of Personally Identifiable Data
1. Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services to Enrollees covered by the Contractor under any Contract or Program and must disclose the information only to its employees on a strict need-to-know basis.
2. Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

D. Acceptable Use of Contractor Data
The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use

personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

4.0 Payment and Taxes

4.1 Payment Terms

I. General

A. Contracts are full-risk.

B. State may implement a risk mitigation strategy for the Healthy Michigan Plan payments if delineated in the rate certification letter from the State's actuary.

II. Payment Provisions

A. Fixed Price

Payment under this Contract will consist of a fixed reimbursement plan with specific monthly payments. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made.

B. Maternity Case Rate

MDHHS will pay a maternity case rate payment to the Contractor for Enrollees who give birth while enrolled in the Contractor's plan.

C. Capitation Rates

MDHHS will establish actuarially sound capitation rates developed in accordance with the federal requirements for actuarial soundness (see Appendix 13). The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent capitation rate development methodology that incorporates relevant information which may include:

1. The annual financial filings of all Contractors.
2. Relevant Medicaid FFS data.
3. Relevant Contractor encounter data.

D. Risk Adjustment

The price per covered member will be risk adjusted (i.e., it will vary for different categories of Enrollees). For Enrollees in the Temporary Assistance for Needy Families (TANF) program categories, the risk adjustment will be based on age and gender. For Enrollees in the Blind and Disabled program category, Michigan will utilize the Chronic Illness and Disability Payment System (CDPS) or another comparable risk adjustment methodology to adjust the capitation rates paid to the Contractor. Under CDPS, diagnosis coding as reported on claim and encounter transactions are used to compute a score for each Enrollee. Enrollees with inadequate eligibility history will be excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case mix value for each Contractor based on its enrolled population.

E. Regional Rate

The regional rate for the Aging, Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each Contractor. The aggregate impact will be budget or rate neutral. MDHHS will fully re-base the risk adjustment system annually. A limited adjustment to the case mix adjusted rates will occur in the intervening six month intervals based only on Contractor enrollment shifts.

F. Annual Review

MDHHS will annually review changes in implemented Medicaid Policy to determine the financial impact on the CHCP. Medicaid Policy changes reviewed under this Section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in covered services, and modifications to Medicaid rates for covered services. If MDHHS determines that the policy changes significantly affect the overall cost to the CHCP, MDHHS will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

G. Enrollment Files

MDHHS will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, MDHHS will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and MDHHS will report payments to Contractors on a HIPAA-compliant 820 file. A process will be in place to ensure timely payments and to identify Enrollees the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns). MDHHS may initiate a process to recoup capitation payments made to the Contractor for Enrollees who were retroactively disenrolled or who are granted retroactive Medicare coverage.

H. Contract Remedies and Performance Bonus Payments
The application of Contract remedies and performance bonus payments outlined in this Contract will affect the lump-sum payment. Payments in any given fiscal year are contingent upon and subject to federal and State appropriations.

III. Contractor Performance Bonus

A. Performance Bonus
During each Contract year, MDHHS will withhold 1.00% of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. Awards will be made to Contractors according to criteria established by MDHHS.

B. Criteria for Performance Bonus
The criteria for awards will include, but is not limited to, assessment of performance in quality of care, access to care, Enrollee satisfaction, and administrative functions. Each year, MDHHS will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

4.2 Taxes

I. Tax Excluded from Price

A. Sales and Use Tax
Generally, the State is exempt from sales and use tax for direct purchases. Contractor's prices must not include sales or use tax unless a specific exception applies.

B. Use Tax
Specific Exception: MCL 205.93f sets out a specific exception to the State's general use tax exemption. This exception applies to contracts for purchase of medical services beginning April 1, 2014 from entities identified in MCL 400.106(2)(a) and MCL 400.109f involving certain Medicaid contracted health plans and some specialty prepaid health plans. Purchases of services that fall under these provisions are subject to use tax.

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

II. Employment Taxes

The Contractor must collect and pay all applicable federal, State, and local employment taxes, including the taxes.

III. Sales and Use Taxes

A. Contractor Remittance of Sale Tax
Contractor is required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors lacking sufficient presence in Michigan to be required to register and pay taxes must do so voluntarily. This requirement extends to:

1. All members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member.

2. All organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes.

B. Organization Definition
In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

5.0 Health Insurance Portability and Accountability Act (HIPAA)

5.1 HIPAA Business Associate Agreement Addendum

At the time of Contract execution, the Contractor ("Business Associate") must sign and return a Health Insurance Portability and (HIPAA) Business Associate Agreement Addendum (Appendix 10) to the individual specified in the Standard Contract Terms (2) of the Contract. The Business Associate performs certain services for the State ("Covered Entity") under the Contract that requires the exchange of information including protected health information under the HIPAA of 1996, as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5). The HIPAA Business Associate Agreement Addendum establishes the responsibilities of both parties regarding HIPAA-covered information and ensures the underlying contract complies with HIPAA.

DEFINITIONS

Term	Definition
Advance Directive	A written legal instruction, such as a living will, personal directive, advance decision, durable power of attorney or health care proxy, where a person specifies what actions should be taken relating to the provision of health care when the individual is incapacitated.
Advisory Committee on Immunization Practices (ACIP)	A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
Agent (of the entity)	Any person who has express or implied authority to obligate or act on behalf of the State, Contractor, Subcontractor, or network provider.
Beneficiary	Any person determined eligible for the Medical Assistance Program.
Blanket Purchase Order	Alternative term for “Contract” used in the State’s computer system Michigan Automated Information Network (MAIN).
Bundled payments	A value-based payment model rewarding providers for various outcomes.
Business Day	Monday through Friday, 8:00 AM through 5:00 PM EST (unless otherwise stated) not including State or federal holidays.
Clinical Advisory Committee (CAC)	Clinical Advisory Committee appointed by MDHHS.
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
Capitated Rate	A fixed per person monthly rate payable to the Contractor by MDHHS for provision of all covered services defined within this Contract.
Capitation Payment (see Capitated Rate)	A payee receives a specified amount per patient to deliver services over a set period of time. Usually the payment is determined on a per member/per month (PMPM) basis.
Children's Special Health Care Services (CSHCS)	Eligibility is authorized by Title V of the Social Security Act. Individuals eligible for both CSHCS and Medicaid are mandatorily enrolled into a health plan.
Collaboration	A process of working with others to achieve shared goals.
Community Collaboration	A plan for developing policies and defining actions to improve population health.
Community Health Needs Assessment (CHNA)	A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community’s health needs and identified issues.
Community Health Workers (CHWs) or Peer-Support Specialists	Frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
CMHSP	Community Mental Health Services Program
Community-based health	A strong focus on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities by coordinating population health improvement strategies.
Contract	A binding agreement entered into by the State of Michigan and the Contractor; see also “Blanket Purchase Order.”
Contractor	Successful Bidder who was awarded a Contract. In this Contract, the terms Contractor, HMO, Contractor’s plan, Medicaid health plan, MHP and health plan are used interchangeably.
Covered Services	All services provided under Medicaid, as defined in the Contract that the Contractor has agreed to provide or arrange to be provided.

Term	Definition
Culturally and Linguistically Appropriate Services (CLAS)	Health Care goal to reduce health disparities and to provide optimal care to patients regardless of their race, ethnic background, native languages spoken, and religious or cultural beliefs.
Data Exchange Gateway (DEG)	A secure electronic location for files to be transferred between MDHHS, Contractors and their agents.
Days	Calendar days unless otherwise specified.
Deliverables	Physical goods and/or commodities as required or identified under the Contractor Requirements.
Diagnosis related group (DRG)	Defined in the Medicaid Institutional Provider Chapter as hospital payments including applicable outliers and capital costs at the per-discharge rate.
DIFS	Department of Insurance and Financial Services
Durable Medical Equipment (DME)	Medical equipment and supplies provided by specialized providers and/or pharmacies which may require prior authorizations.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Federal mandate that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
Electronic funds transfer (EFT)	Ability to electronically exchange funds between entities.
Electronic health record (EHR)	Ability to electronically exchange eligibility and claim information with providers.
Emergency Medical Services (EMS)	Those services necessary to treat an emergency medical condition.
Emergency Treatment and Active Labor Act (EMTALA)	Enrollees must be screened and stabilized without prior authorization.
Enrollee	Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in a given Medicaid health plan.
Enrollee Appeal	An Enrollee's request for review of a Contractor's decision that results in full or partial denial, reduction of limitation of covered services or authorizations, including the failure to act within the established timeframes for grievance and appeal disposition.
Enrollment Capacity	The number of persons that the Contractor can serve through its provider network under a Contract with the State. Enrollment Capacity is determined by a Contractor based upon its provider network organizational capacity and available risk-based capital.
Enrollment Services Contractor	An entity contracted with MDHHS to contact and educate general Medicaid beneficiaries about managed care and to assist beneficiaries to enroll, dis-enroll, and change enrollment with their Contractor.
Expedited Appeal	An appeal conducted when the Contractor determines (based on the Enrollee request) or the provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Contractor decision must be made within 72 hours of receipt of an expedited appeal.
Expedited Authorization Decision	An authorization decision required to be expedited due to a request by the provider or determination by the Contractor that following the standard timeframe could seriously jeopardize the Enrollee's life or health. Contractor's decision must be made in 3 working days from the date of receipt.
Experimental/Investigational	Drugs, biological agents procedures, devices or equipment determined by the Medical Services Administration, that have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used.

Term	Definition
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
Explanation of Benefits (EOB)	Statement to covered individuals explaining the medical care or services that were paid for on their behalf.
External Quality Review (EQR)	Performance improvement goals, objectives and activities which are part of the Contractor's written plan for the Quality Assessment and Performance Improvement Program (QAPI).
Federally Qualified Health Center (FQHC)	Community-based organizations that provide comprehensive health care services to persons of all ages, regardless of their ability to pay or health insurance status with no authorization required.
Fee-for-service. (FFS)	A reimbursement methodology that provides a payment amount for each individual service delivered.
Financial Independence Program (FIP)	Medicaid eligible group mandatorily enrolled in the CHCP.
Fiscal Agent	An entity that manages fiscal matters on behalf of another party.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).
Fraud, Waste and Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Freedom of Information Act (FOIA)	Allows access by the general public to data held by national governments.
Grievance	Grievance means an expression of dissatisfaction about any matter other than an action subject to appeal. (42 CFR 438.400)
Habilitative Service	Service that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Benefit Manager (HBM)	Any entity that arranges for the provision of health services covered, excluding transportation, under a written contract or agreement with the Contractor.
Health Disparities	A particular type of health difference that is closely linked with social or economic disadvantage.
Health Equity	When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
Health Insurance Portability and Accountability Act (HIPAA)	The protection of medical records and information insuring any individual's information is secure and only shared with others through their consent.
Health Maintenance Organization (HMO)	An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 500.3501.
Health Risk Assessment	Protocol approved by MDHHS to measure readiness to change and specific healthy behaviors of HMP Enrollees.
Healthcare Effectiveness Data and Information Set (HEDIS®)	The result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a widely used set of performance measures that provides some objective information with which to evaluate health plans and hold them accountable.

Term	Definition
Healthy Michigan Plan (HMP)	Approved CMS Program to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.
Indian Health Services/Tribal Health Centers/Urban Indian Organizations (I/T/U)	Health care providers specifically for Native Americans.
Initial Enrollment	First enrollment in Medicaid Health Plan following determination of eligibility; re-enrollment in a Medicaid Health Plan following a gap in eligibility of less than two month is not considered initial enrollment.
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	Care facilities specifically for persons determined mentally retarded.
LARA	Licensing and Regulatory Affairs.
List of Excluded Individuals/Entities (LEIE)	List of Excluded Individuals/Entities. List of people/entities who have been debarred or otherwise excluded under the Federal Acquisition Regulations and are not allowed to be in the Contractor's provider network.
Limited Capitation (Payment) Models	Under partial or blended capitation models, only certain types or categories of services are paid on a capitated basis.
Marketing	In the Contractor's approved service area they may promote their services to the general population of an entire city, county or larger population segment in the community.
Marketing Materials	MDHHS must approve materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential Enrollees.
MCL	Michigan Compiled Laws
MED	Medicare Exclusion Database
Medicaid Health Plan (MHP)	Managed care organizations that provide or arrange for the delivery of comprehensive health care services to Medicaid Enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as a Health Maintenance Organization (HMO). See also Contractor.
Medical Eligibility Referral Form (MERF)	Documentation to determine medical eligibility for the CSHCS program.
MI Health Account	An account operated by the Contractor or the Contractor's vendor into which money from any source, including, but not limited to, the Enrollee, the Enrollee's employer, and private or public entities on the Enrollee's behalf, can be deposited to pay for incurred health expenses.
Michigan Care Improvement Registry (MCIR)	Contractor and their providers must participate with and submit Enrollee data to MCIR.
NAIC	National Association of Insurance Commissioners
NPPES	National Plan and Provider Enumeration System
NCQA	National Committee for Quality Assurance
PACE	Program for All-Inclusive Care for the Elderly
Patient-Centered Medical Home (PCMH)	Model of care to ensure patient care is managed across a continuum of care and specialty services will be accessed as appropriate.
Per Member Per Month (PMPM)	Capitated unit price payments to contracted primary care.
Persons with Special Health Care Needs (PSHCN)	Enrollees who have lost eligibility for the Children's Special Health Care Services (CSHCS) program due to the program's age requirements.
PIP	Physician Incentive Plan

Term	Definition
Population Health	Management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.
Potential Enrollee	Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of a specific Contractor or other Managed Care Organization.
Prepaid Inpatient Health Plan (PIHP)	Provides behavioral health services to Enrollees.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
Primary Care Provider (PCP)	Those providers within the MHPs who are designated as responsible for providing or arranging health care for specified Enrollees of the Contractor.
Provider	Provider means a health facility or a person licensed, certified, or registered.
Quality Assessment and Performance Improvement Program (QAPI)	An ongoing program for the services furnished to the Contractor's Enrollees that meets the requirements of 42 CFR 438.240.
QIC	Quality Improvement Committee
Rural	Rural is defined as any county not designated as metropolitan or outlying metropolitan by the 2000 U. S. Census.
SAM	System for Award Management (www.sam.gov)
Services	Any function performed for the benefit of the State.
Sexually-Transmitted Infection (STI)	Serious infections that can be screened for and may be treated with early identification.
Social Determinants of Health	The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.
State Fair Hearing	An impartial review by MDHHS of a decision made by the Contractor that the Enrollee believes is inappropriate.
Subcontractor	Any person or entity that performs required, ongoing administrative or Health Benefit management functions for the Contractor.
Temporary Assistance to Needy Families (TANF)	Program code for Medicaid beneficiaries that determines that capitation rate to the MHPs.
Third Party Liability (TPL)	Other health insurance plan or carrier.
United States Code (USC)	Federal regulations
Utilization Management (UM)	Medical decisions relating to an individual's care.
Vaccines for Children program (VFC)	A federal program which makes vaccine available free to immunize children age 18 and under who are Medicaid eligible.
Women Infants and Children (WIC)	A supplemental Food and Nutrition Program.

APPENDIX 1
RURAL AREA EXCEPTIONS COUNTIES

The following Michigan counties have been approved by CMS as rural for the purpose of implementing the exception for rural area residents, allowing the State to limit a rural area resident to a single managed care organization. Only the counties in the Upper Peninsula currently operate under this exception.

Upper Peninsula	Lower Peninsula
Alger	Alcona
Baraga	Alpena
Chippewa	Arenac
Delta	Bay
Dickinson	Benzie
Gogebic	Clare
Houghton	Crawford
Iron	Gladwin
Keweenaw	Gratiot
Luce	Huron
Mackinac	Iosco
Marquette	Isabella
Menominee	Manistee
Ontonagon	Midland
Schoolcraft	Missaukee
	Montmorency
	Ogemaw
	Oscoda
	Otsego
	Presque Isle
	Roscommon
	Saginaw
	Sanilac
	Tuscola
	Wexford

APPENDIX 2
MDHHS FINANCIAL MONITORING STANDARDS

Reporting Period	Monitoring Indicator	Threshold	MDHHS Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	MDHHS written notification.	Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Net Worth	Negative Net Worth	MDHHS written notification. Freeze auto assigned enrollees.	Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Medical Loss Ratio	83%	MDHHS written notification.	Informational only.
Annual Financial Statement	Risk Based Capital (RBC)	150-200% RBC	MDHHS written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	RBC	100-149% RBC	MDHHS written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	RBC	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

APPENDIX 3
REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

Note: The annual reporting requirements and due dates are subject to change.

The **MDHHS File Transfer Application** must be used to share all reports **except** encounter data, provider file, and the PCP Submission file which are submitted via the Data Exchange Gateway.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Consolidated Annual Report	3/15/16	1/1/15 – 12/31/15	Contract 3.2. II. A
• Health Plan Profile (MSA 126 (01/06)) NOTE: **Follow instructions carefully and include all required attachments.** • Financial (NAIC, all reports required by DIFS, and Statement of Actuarial Opinion are due with the annual report on 3/15/16). *NOTE: The Management Discussion and Analysis is due 4/15/16 and the Audited Financial Statements are due 6/15/16.* • Health Plan Data Certification Form (MSA 2012 (03/13)). • Litigation (limited to litigation directly naming health plan, MSA 129 (09/99)) • Physician Incentive Program (PIP) Reporting (MDHHS PIP Attestation form and PIP Disclosure forms) • Provider Manual, Certificate of Coverage, Member Handbook (WR only) • EPSDT Requirements: ○ **Incentives:** List, with brief description, member incentives offered to increase member utilization of EPSDT services; List, with brief description, provider incentives offered to increase monitoring of/providing EPSDT services			
Michigan Medicaid Tobacco Cessation Benefits Grid	6/15/16	Current, up-to-date, per contract	Exhibit A: Section 1.1. VI. G., Use MI Medicaid Tobacco Cessation Benefits Grid as provided by MDHHS in January
Management Discussion and Analysis for Annual Financial	4/15/16	1/1/15 – 12/31/15	Exhibit A: Section 3.2. II. C.
Audited Financial Statements	6/15/16	1/1/15 – 12/31/15	NAIC, DIFS
QIP Annual Evaluation and Work Plan	6/15/16	Current, Approved 2015 Evaluation, 2016 Work Plan	Electronic Format; Exhibit A: Section 3.2. II. B.
Medicaid Health Equity Template	8/15/16	1/1/15 – 12/31/15	Use the template provided by MDHHS in March
HEDIS® Compliance Audit – Final Audit Report	8/15/16	1/1/15 – 12/31/15	NCQA formatted, electronic copy
HEDIS® IDSS	7/15/16	1/1/15 – 12/31/15	NCQA formatted, electronic copy
• Auditor-locked Excel format Audit Review Table (ART) • Excel Downloads: Comma Separated Values (CSV) Workbook • Excel Downloads: Data-filled Workbook (measure level detail file), and • Copy of MHP's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter			
Quarterly Submissions			
Financial	5/15/16 8/15/16 11/15/16	1/1/16 – 3/31/16 4/1/16 – 6/30/16 7/1/16 – 9/30/16	NAIC and DIFS

Grievance/Appeal	1/30/16 4/30/16 7/30/16 10/30/16	10/1/15 – 12/31/15 1/1/16 – 3/31/16 4/1/16 – 6/30/16 7/1/16 – 9/30/16	MSA 131 (11/11), Grievance & Appeal Report
Third Party Collection	5/15/16 8/15/16 11/15/16	1/1/16 – 3/31/16 4/1/16 – 6/30/16 7/1/16 – 9/30/16	Report on separate sheet and send with NAIC
Monthly Submissions			
Claims Processing	30 days after end of the month NOT last day of month	• Data covers previous month • e.g., data for 2/16 due by 3/30/16	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • e.g., data for 1/16 due by 2/15/16	837 Format NCPDP Format
Provider Files (4275)	Friday before the last Saturday of each month	• Submit all providers contracted with the plan on the date of submission • Submit four files, utilizing the provider voluntary ID for Benefit Plans: *MA-MC *CSHCS-MC *MME-MC *HMP-MC	4275 layout and file edits distributed by MDHHS
PCP Submission Files (5284)	Weekly if PCP name is NOT on ID card; otherwise at least one monthly	Submit all new and end-dated PCP relationships since the previous submission. Submit a complete refresh file during the time period required by MDHHS	5284 layout and file edits distributed by MDHHS
Health Risk Assessment File (5708)	At least one file prior to the 20th of each month	Once the initial appointment is complete, plans will have 60 days to transmit the associated HRA data to MDHHS via the 5708 file layout.	5708 Layout and file edits distributed by MDHHS

APPENDIX 4
Performance Monitoring Standards

Note: The performance monitoring standards are subject to change.

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address following:

- Medicaid Managed Care
- Healthy Michigan Plan
- Adult Core Set Measures

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Minimum performance monitoring standards for FY 2016 are included in this document. **Ten percent (10%) annual improvement towards the standard will also constitute meeting the standard for that performance measure.**

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in Exhibit A **Section 1.1 XI-K**.

MEDICAID MANAGED CARE

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Childhood Immunization**	Fully immunize children who turn two years old during the measurement Period.	**N/A**	MDHHS Data Warehouse	Quarterly
• **Elective Delivery**	Pregnant women with elective vaginal deliveries or elective cesarean sections at between 37 and 39 weeks completed gestation.	**N/A**	MDHHS Data Warehouse	Quarterly
• **Postpartum Care**	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	**≥70%**	MDHHS Data Warehouse	Quarterly
• **Blood Lead Testing**	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	**≥81%** continuous enrollment	MDHHS Data Warehouse	Quarterly
• **Developmental Screening**	Children less than one (1) year old who had a developmental screening Children between their 1st and 2nd birthday who receive a developmental screening Children between their 2nd and 3rd birthday who receive a developmental screening	**≥19%** First year of life **≥23%** Second year of life **≥17%** Third year of life	MDHHS Data Warehouse	Monthly
• **Well-Child Visits in the First 15 Months of Life**	Children 15 months of age receive six or more well child visits during first 15 months of life	**≥71%**	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**	Children three, four, five, and six years old receive one or more well child visits during measurement period.	**≥79%**	MDHHS Data Warehouse	Quarterly
• **Customer Services:** Enrollee Complaints	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate ≤0.15 per 1000 member months	Customer Relations Management (CRM)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims processed within 30 days, ≤1% of ending inventory over 45 days old; ≤12% denied claims	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDHHS Data Exchange Gateway (DEG) and MDHHS Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDHHS Data Exchange Gateway (DEG) and MDHHS Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Accurate submission	MI Enrolls	Monthly

HEALTHY MICHIGAN PLAN

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Adults' Generic Drug Utilization**	Enrollees who had a generic prescription filled during the measurement period	**≥80%**	MDHHS Data Warehouse	Quarterly
• **Timely Completion of Initial Health Risk Assessment (HRA)**	Enrollees who had an HRA completed within 150 days of enrollment in a health plan	**≥20%**	MDHHS Data Warehouse	Quarterly
• **Outreach and Engagement to Facilitate Entry to Primary Care**	Enrollees who had an ambulatory or preventive care visit within 150 days of enrollment in a health plan who had not previously had one since enrollment in Healthy Michigan Plan	**≥66%**	MDHHS Data Warehouse	Quarterly
• **Plan All-Cause Acute 30-Day Readmissions**	Acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days	**≤16%**	MDHHS Data Warehouse	Annually
• **Adults' Access to Ambulatory Health Services**	Enrollees who had an ambulatory or preventive care visit during the measurement period	**≥87%**	MDHHS Data Warehouse	Quarterly

ADULT CORE SET MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Adult Body Mass Index (BMI) Assessment**	Enrollees ages, 18 to 74, who had an outpatient visit and whose BMI was documented during the measurement period or the year prior to the measurement period	**≥79%**	MDHHS Data Warehouse	Quarterly
• **Breast Cancer Screening**	Women enrolled in a health plan, ages 50 to 74, who received a mammogram to screen for breast cancer during the measurement period or the two (2) years prior to the measurement period	**≥58%**	MDHHS Data Warehouse	Quarterly
• **Cervical Cancer Screening**	Women enrolled in a health plan, ages 21 to 64, who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed every three (3) years • Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years	**≥72%**	MDHHS Data Warehouse	Quarterly
• **Diabetes Short-Term Complications Admissions Rate**	The rate of enrollees in a health plan ages 18+ who were discharged for diabetes short-term complications per 100,000 member months	**Informational Only**	MDHHS Data Warehouse	Quarterly
• **COPD or Asthma in Older Adults Admission Rate**	The rate of enrollees in a health plan ages 40+ who were discharged for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months	**Informational Only**	MDHHS Data Warehouse	Quarterly
• **Heart Failure Admission Rate**	The rate of enrollees in a health plan ages 18+ who were discharged for heart failure per 100,000 member months	**Informational Only**	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Asthma in Younger Adults Admission Rate**	The rate of enrollees in a health plan, ages 18 to 39 who were discharged for asthma 100,000 member months	**Informational Only**	MDHHS Data Warehouse	Quarterly
• **Chlamydia Screening in Women**	Women enrolled in a health plan, ages 21 to 24, who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period	**≥71%**	MDHHS Data Warehouse	Quarterly
• **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing**	Enrollees, ages 18 to 75, with Type 1 or Type 2 diabetes who had an HbA1c test.	**≥87%**	MDHHS Data Warehouse	Quarterly
• **Antidepressant Medication Management**	Enrollees, age 18+, with a diagnosis of major depression and who were treated with antidepressant medication, who remained on an antidepressant medication treatment	**≥56%** Acute Phase Treatment **≥40%** Continuous Phase Treatment	MDHHS Data Warehouse	Quarterly
• **Annual Monitoring for Patients on Persistent Medications**	Enrollees, age 18+, who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and who received annual monitoring for the therapeutic agent in the measurement period	**≥87%**	MDHHS Data Warehouse	Quarterly

APPENDIX 5a
Performance Bonus Template

Note: Performance bonus template categories, etc. are subject to change.

Medicaid Health Plan Name	Performance Bonus Template			2015 NCQA Medicaid Percentiles	
Clinical Measures - 2016 HEDIS	**HEDIS Score**	**10% Improvement (1 point) 75% (2 points) 90% (4 points)**	**10%**	**75%**	**90%**
Women's Care					
Breast Cancer					
Cervical Cancer					
Chlamydia - Combined Rate					
Prenatal Care					
Postpartum Care					
Living with Illness					
HbA1c test					
HbA1c poor control (>9%)					
Diabetes Eye Exam					
Diabetes w/ Blood Pressure Control (<140/90)					
Controlling High Blood Pressure					
Medication management for People with Asthma-Total					
Medication management for People with Asthma-Ages 5 to 11					
Adult BMI					
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits					
3-6 Years					
Adolescent					
Other					
Children BMI					
Childhood - Combo 3					
Blood Lead					
Adolescent - Combo 1					

HPV					
Appropriate treatment for Children with URI					
Appropriate testing for Children with Pharyngitis					
Access to Care Measures - 2016 HEDIS	**HEDIS Score**	**10% Improvement (1 point) 75% (2 points) 90% (4 points)**	**10%**	**75%**	**90%**
12-24 Months					
25 Months - 6 Years					
7-11 Years					
12-19 Years					
Healthy Michigan Plan - 2016 PMR	**PMR Score**	**Minimum Standard**	**10% Improvement but below standard (4 points) At or above standard (8 points)**		
Adults' Generic Drug Utilization		80%			
Timely Completion of HRA		20%			
Outreach/Engagement		66%			
All-Cause Acute 30-day Readmissions (reverse)		16%			
Adults' Access to Ambulatory Health Services		87%			
2016 CAHPS	**CAHPS Score**	**10% Improvement (1 point) 75% (2 points) 90% (4 points)**	**10%**	**75%**	**90%**
Adult					
Getting Needed Care					
Getting Care Quickly					
Customer Service					
All Health Care					
Flu Shot					
Health Plan Rating					
Child					
Getting Needed Care					
Getting Care Quickly					
Customer Service					
All Health Care					
Health Plan Rating					
CSHCS					
Getting Needed Care					
Getting Care Quickly					

Customer Service
Access to Prescription Medicines
All Health Care
Health Plan Rating
Healthy Michigan Plan
Getting Needed Care
Getting Care Quickly
Customer Service
All Health Care
Health Plan Rating

Compliance Review - 2016					
TBA					

Point Summary	Possible Points	Health Plan Points	
Clinical Measures (40%)	TBA		
Access to Care Measures (10%)	TBA		
Survey Measures (CAHPS) (20%)	TBA		
Healthy Michigan Measures (PMR) (20%)	TBA		
Compliance Review (10%)	TBA		
Performance Bonus Template Score	**TBA**		

APPENDIX 5b
Pay for Performance on Population Health and Health Equity

Note: Pay for Performance categories and criteria/deliverables are subject to change.

PURPOSE: The purpose of the 2016 Pay for Performance is to promote health equity and to reduce racial and ethnic disparities among the Michigan Medicaid managed care population.

The 2016 Pay for Performance on Population Health and Health Equity will focus on five specific areas:

- Medicaid Health Equity;
- Chlamydia Screening (CHL);
- Population Health Management;
- Non-Emergent Medical Transportation (NEMT); and
- Tobacco Cessation.

Medicaid Health Equity

CONTEXT: Racial and ethnic minority populations experience worse health outcomes than the general population for almost every health condition. Two HEDIS measures (Postpartum Care and Childhood Immunizations Status – Combination 3) have been selected for disparity reduction benchmarks because both of these measures have an Index of Disparity greater than 5% for the Michigan Medicaid managed care population.

GOAL: Medicaid health plans will implement a health equity program and complete an annual Medicaid Health Equity Project template. DHHS will monitor efforts to reduce racial/ethnic disparities in the two HEDIS measures listed above.

INSTRUCTIONS: Email all documents to Meta Kreiner at kreinerm@michigan.gov . The subject line should be labeled as 2016P4P- Medicaid Health Equity.

Chlamydia Screening (CHL)

CONTEXT: The racial/ethnic disparity in rates for the Chlamydia screening (CHL) measure has been the largest disparity for any measure included in the Medicaid Health Equity Project for three years running. Screening programs focused on those presumed to be at risk limits appropriate screening. This HEDIS measure does not include men even though they may also need STI screening. Partner screening and treatment are essential to reduce reinfection and complications. For these reasons, this project will target CHL screening for men ages 16-18 and women ages 16 -24 years as well as CHL screening rates by race/ethnicity.

GOAL: Medicaid health plans will describe and implement programs/efforts to improve screening and treatment rates, and narrow any health disparities in their population due to sex or race/ethnicity.

INSTRUCTIONS: Email all documents to Rachel Copeland at copelandr1@michigan.gov. The subject line should be labeled as 2016P4P- Chlamydia Screening.

Population Health Management
CONTEXT: An individual's health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Housing, nutrition and other dynamics are often collectively referred to as "social determinants of health". Social determinants are conditions in which people are born, grow, live, work and age. Social determinants of health are cited as factors that collectively have the most significant influence on health outcomes. Community Health Workers (CHW) have been documented as a successful strategy to improve member wellbeing.

GOAL: Medicaid health plans will implement a Population Health Management program, a Community Health Worker program and other procedures to address social determinants of health for their members.

INSTRUCTIONS: Email all documents to Rachel Copeland at copelandr1@michigan.gov. The subject line should be labeled as 2016P4P - Population Health Management.

Non-Emergent Medical Transportation (NEMT)
CONTEXT: In recent years, there has been a growing recognition that transportation services are a vital component of any comprehensive medical care program. Going without medical care has negative consequences for the patient and the medical care system. Well-designed, well-coordinated transportation systems can help save medical costs, increase positive healthcare outcomes and increase the quality of life.

GOAL: Medicaid health plans will provide adequate NEMT services to HMP, MA-MC and CHSCS beneficiaries and submit accurate and timely encounters for these services. MDHHS will monitor health plan efforts to provide NEMT services.
INSTRUCTIONS: Email all documents to Sandra Greyerbiehl greyerbiehls@michigan.gov . The subject line should be labeled as 2016_P4P-Non-Emergent_Medical_Transportation.

Tobacco Cessation
CONTEXT: Tobacco smoking increases the risk for serious health problems, many diseases, and death. People who stop smoking greatly reduce their risk for these negative outcomes and healthcare delivery systems are critical components of tobacco cessation efforts. In support of these goals, the Healthy Michigan Plan Health Risk Assessment (HRA) includes of a set of questions to help identify members that use tobacco and have the desire to quit or reduce tobacco use.

GOAL: Medicaid health plans will identify tobacco users through the Healthy Michigan Plan HRA, CAHPS survey and other health plan data systems. DHHS will monitor health plan efforts to support tobacco cessation.

INSTRUCTIONS: Email all documents to Sandra Greyerbiehl at greyerbiehls@michigan.gov. The subject line should be labeled as 2016_P4P_Tobacco

Scoring
Total points available for the 2016 Pay for Performance on Population Health and Health Equity is 120 points. Health plans with small sub-populations may not be able to earn full points for all criteria. These criteria are marked with an asterisk (*). In these situations, these health plans will receive guidance regarding acceptable alternative submissions or their score will be calculated based on a smaller number of total points.

MEDICAID HEALTH EQUITY

PERFORMANCE AREA	CRITERIA/DELIVERABLES			DUE DATE AND POINTS
	GOAL	**MINIMUM STANDARD**	**DATA SOURCE**	
Health Equity Program	1. Policy/Procedure for plan-specific Health Equity Program (*III. Population Health Management*). a. Health Plans must offer evidence-based interventions that have a demonstrated ability to reduce health disparities. b. Health Plans must stratify new members on a monthly basis. c. Health Plans must utilize information such as claims data, pharmacy data, laboratory results, UM data, health risk assessment results, and eligibility and measure status to monitor for health disparities. d. Health Plans must provide a plan for reporting annually to MDHHS on the effectiveness of its evidence-based interventions to reduce health disparities. e. Health Plans must implement the U.S. DHHS Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/ 2. Submit description of any additional programs/policies/efforts for improving health disparities within health plan membership (for example, Population Health Management; Quality Improvement Initiatives; Community Collaboration Projects). 3. Work plan/Description of intervention(s) to narrow disparities carried out during calendar year.			March 15, 2016 **25 points**

MEDICAID HEALTH EQUITY

PERFORMANCE AREA	CRITERIA/DELIVERABLES			DUE DATE AND POINTS
	GOAL	**MINIMUM STANDARD**	**DATA SOURCE**	
Medicaid Health Equity Project Template	Submit DHHS provided Medicaid Health Equity Template for audited HEDIS administrative data following the instructions provided.			August 15, 2016 **5 points**
Index of Disparity Measures*	Narrow disparity between racial/ethnic populations for the following measures: 1. Childhood Immunization Status Combo 3 2. Postpartum Care	Health Plan Index of Disparity for *each measure* is equal to or less than 5.00%	Medicaid Health Equity Project 2016	September 15, 2016 **10 points** *(5 points per measure)*
Race/Ethnicity Diversity of Membership	Race/ethnicity is collected from members through self-report for improving access to culturally competent care, monitor health disparities and respond to reports of racial/ethnic discrimination. Race/ethnicity information is provided to health plans on enrollment file.	HEDIS 2016 “unknown” race/ethnicity is less than or within one percentage point of the “unknown” race/ethnicity in the MDHHS Data Warehouse for health plan population.	HEDIS 2016 and MDHHS Data Warehouse	September 15, 2016 **5 points**

* Health plans with small sub-populations may not be able to earn full points for all criteria. In these situations, these health plans will receive guidance regarding acceptable alternative submissions or their score will be calculated based on a smaller number of total points.

CHLAMYDIA SCREENING

PERFORMANCE AREA	CRITERIA/DELIVERABLES	DUE DATE AND POINTS
Chlamydia Screening Population Health Approach	The Chlamydia Screening Project intends a population health approach to improve the health of members through care of the total population, with a focus on health outcomes as well as health care processes. 1. Health Plans will provide a program description for improving Chlamydia (CHL) screening rates based on guidelines for males and females: Male ages 16-18 years (AAP Recommendations); Females 16-24 years (CDC and USPHTF Guidelines and Recommendations) 2. Health Plans will submit description of interventions to educate providers and members about importance of screening. This can include: a. Discussing improvement strategies with providers/practice (For example, using newsletters or other provider communication methods to share strategies for working with front line staff to standardize urine sample collection and/or check patients' last STI test date, etc.) b. Increasing provider awareness of state and national CHL disease burden and current STI treatment guidelines, including identification of high risk populations (For instance via webinars, blast fax, online training, etc.) c. Partnering with schools to educate/screen/improve access to screening and treatment for young people (CDC Evidence Based Programs). d. Efforts to educate members on screening process (confidential, urine test) and importance of sexual health. 3. Describe education/outreach to members and providers about DHHS Expedited Partner Therapy (EPT) program (CDC/MDHHS-PA 525 (2014)) and public health resources (For instance via newsletters, etc.)	April 1, 2016 **15 points** *(5 points per criterion)*
Chlamydia Screening addressing racial/ethnic health disparities	The Chlamydia Screening (CHL) measure has the largest racial/ethnic disparity of all quality measures analyzed for racial/ethnic disparities. Chlamydia screening rates for all racial/ethnic populations will continue to be monitored using DHHS warehouse data and Medicaid Health Equity Project data. The goal is a Health Plan Index of Disparity for this measure which is equal to or less than 5.00%. 1. Health Plans will provide a description of intervention(s) to narrow disparity during intervention year. Intervention strategies must target reducing disparity without lowering rate in African American population. Scoring for this criterion is based on description of intervention to lower Index of Disparity.	April 1, 2016 **10 points**

POPULATION HEALTH MANAGEMENT

PERFORMANCE AREA	CRITERIA/DELIVERABLES	DUE DATE AND POINTS
Population Health Management	Submit multi-year plan and policies/procedures for data analysis to support population health management for MDHHS approval. This plan must include: 1. Which social determinants of health will be added 2. The manner in which social determinant data will be collect and analyzed for each Enrollee 3. The manner in which the social determinant risk determinants are validated 4. Timeline for implementing the new factors into the data analysis 5. Plan for training Contractor staff and embedded care managers on using the social determinants data incorporated into the data analysis 6. Subpopulations experiencing a disparate level of social needs: transportation, housing, food access, unemployment or education level 7. Subpopulation demonstrating disparate levels of poor health outcomes or access issues based: race, ethnicity, gender, age, primary language, deaf/hard of hearing, ability, geographic location or income level 8. Enrollees who are eligible for Medicaid based on an eligibility designation of disability; Children eligible for CSHCS; People with Special Health Care Needs (PSHCN) 9. Persons with high prevalence Chronic Conditions such as diabetes, obesity and cardiovascular disease 10. Enrollees in need of Complex Care Management, including high risk enrollees with dual behavioral health and medical health diagnoses who are high utilizers of services 11. Women with a high risk pregnancy 12. Other populations with unique needs as identified by MDHHS such as foster children or homeless members 13. Contractor must systematically stratify newly enrolled Enrollee on a monthly basis 14. Systematically re-stratify the entire Enrollee population at designated intervals to ensure Enrollees with increasing health risks and social needs are identified 15. Share with primary care providers to support practice-level population health management activities, as required 16. Submit semi-annual updates regarding plan implementation, noting compliance with respect to the plan timeline, the plan of correction to realign activities to the timeline and timeline revisions, if necessary	August 15, 2015 **10 points**
Addressing Health Disparities	Submit Policies/Procedures to providing population health management services where telephonic and mail based care management is not sufficient or appropriate, including the following areas (Authority: 1.1 X(B)(1)(b)): 1. Adult and family shelter for Enrollees who are homeless 2. The Enrollee's home 3. The Enrollee's place of employment or school 4. At foster home, group homes or other residential placements especially for children in the care or custody of MDHHS.	April 15, 2015 **3 points**

Community Collaboration Project	MHPs must participate with a community-led initiative to improve population health which is approved by MDHHS in each service area region. Submit community collaboration project(s) to MDHHS for approval. This submission should include a narrative that describes MHP's plan to develop or expand community collaboration projects and a detailed timeline (Authority: 1.1X(B)(2).	April 15, 2015 **2 points**
Community Health Worker (CHW) Program	Policy/Program Description for Community Health Worker (CHW) program (III. Population Health Management & VIII. Behavioral Health Integration). 1. Health plans must support design and implementation of CHW interventions & ensure CHWs are equipped to serve Enrollees in the community, understand all privacy laws, HIPAA provisions, and all core competencies (such as navigating community resources, outreach, cultural responsiveness, etc.). 2. Health plans must maintain a CHW to Enrollee ratio of at least one full-time CHW per 20,000 Enrollees. 3. Health plans must provide CHWs to Enrollees who have significant behavioral health issues and complex physical co-morbidities. 4. Health Plans must establish a reimbursement methodology for outreach, engagement, education and coordination services provided by community health workers or peer support specialists to promote behavioral health integration. 5. Examples of CHW services include but are not limited to: Conduct home visits to assess barriers to healthy living and accessing health care; Set up, prepare, accompany, remind and follow-up with members about medical and behavioral health office visits; Advocate for clients with providers; Arrange for social services (such as housing and heating assistance) and surrounding support services; Provide clients with training in self-management skills; and Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives.	April 15, 2016 **10 points**

NON-EMERGENT MEDICAL TRANSPORTATION (NEMT)

PERFORMANCE AREA	**CRITERIA/DELIVERABLES**	**DUE DATE AND POINTS**
Non-Emergency Medical Transportation (NEMT) Policies and Procedures	Health plan must provide non-emergent transportation & submit to MDHHS equivalent policies and procedures. Health Plan must provide NEMT for CSHCS Enrollees with PCPs outside the 30 miles or minutes travel time from the Enrollee's home. Health Plans and their transportation subcontractor's policies/procedures must include the following provisions (VI. Covered Services) 1. Determination of the most appropriate mode of transportation to meet the Enrollee's medical needs, including special transport requirements for Enrollees who are medically fragile or Enrollees with physical/mental challenges, pregnancy status, infancy, need for Enrollee to keep appointments confidential (such as when it is not appropriate for Enrollees to ask neighbors or family members for transportation), additional riders and/or car seats, housing status that affects pick up and drop off locations 2. Prevention of excessive multi-loading of vehicles such that Enrollees are not unduly burdened or forced to travel for significantly longer periods of time than is necessary 3. Scheduling system must be able to schedule Enrollee transportation services in at least three modes: a. On-going prescheduled appointments for at least thirty days, such as, but not limited to, dialysis, chemotherapy or physical therapy b. Regularly scheduled appointments; plans may require reasonable advance notice (e.g. 48 – 72 hours) of the need for transportation c. Urgently scheduled appointments for which the Enrollee requires transportation on the same day as the request or the following day d. Method for reimbursing mileage to individuals when it is appropriate for the Enrollee to drive or be driven to an urgent care facility or emergency department 4. Health Plans may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles; prior authorization may not be denied based on distance alone. 5. Health Plans must make appropriate accommodations for Enrollees with special transportation needs, including but not limited to, CSHCS Enrollees.	September 15, 2016 **5 points**
Non-Emergency Medical Transportation (NEMT) Encounter Submissions	Report on NEMT services provided to members. MDHHS will pull this from encounter data for Jan-June 2016. Plans will be scored on the following criteria: 1. Data submission using appropriate NEMT codes and appropriate provider ID for MA-MC, HMP and CSHCS	September 15, 2016 **5 points**

TOBACCO CESSATION

PERFORMANCE AREA	CRITERIA/DELIVERABLES	DUE DATE AND POINTS
Tobacco Cessation Benefits Grid and Tobacco Cessation Programs	1. Health plan must submit Medicaid Tobacco Cessation Benefits Grid as provided by MDHHS detailing tobacco cessation treatment that includes, at a minimum, the following services: a. Intensive tobacco cessation treatment through an MDHHS-approved quit-line b. Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation medication or without c. Non-nicotine prescription medications d. Prescription inhalers and nasal sprays e. The following over-the-counter agents: Patch, Gum, Lozenge f. Combination therapy – the use of a combination of medications, including but not limited to the following combinations: Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray); Nicotine patch and inhaler; Nicotine patch and bupropion SR g. Health plan must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco treatments. 2. Submit description of any additional programs/policies to support tobacco cessation. Examples can include: report of tobacco quitline by members, health plan tobacco cessation incentive programs for members, collaboration with community-based organizations to support youth tobacco prevention or tobacco cessation for pregnant/postpartum women.	June 15, 2016 **4 points** (2 points per criterion)
Healthy Michigan Plan HRA Tobacco Cessation	1. Healthy Michigan Plan Health Risk Assessment Tobacco Cessation: a. MDHHS will use 5708 Health Risk Assessment (HRA) files (Aug 2015-April 2016) to identify Healthy Michigan Plan (HMP) members who chose tobacco cessation as one of their behaviors to address on the HMP HRA. MDHHS will then use encounter data (Aug 2015-July 2016) to track how many of these HMP members received tobacco cessation counseling and or pharmacotherapy. b. MDHHS will use 5699/5700 Health Risk Assessment (HRA) files (Aug 2015-April 2016) to identify Healthy Michigan Plan (HMP) members who self-reported interest in tobacco cessation through their HRA. MDHHS will then use encounter data (Aug 2015-July 2016) to track how many of these HMP members received tobacco cessation counseling and or pharmacotherapy.	September 15, 2016 **4 points** (2 points per criterion)
Tobacco Cessation Encounter Submissions	1. MDHHS will use encounter data to track tobacco cessation services provided to HMP and MA-MC beneficiaries. Health Plans will be scored on the following criteria for encounters submitted 01/01/2016 through 06/30/2016: a. Timely encounters submission and utilizing appropriate tobacco cessation codes b. Minimum volume	September 15, 2016 **1 point**

Tobacco Cessation CAHPS Score	1. MDHHS will evaluate scores for the HMP and traditional Medicaid populations for the following CAHPS measures: a. Advising smokers and tobacco users to quit b. Discussion cessation medications c. Discussion cessation strategies	September 15, 2016 **6 points** (2 points per criterion)

APPENDIX 5c
Focus Bonus: Emergency Department Utilization
(Worth 40 points each FY on the Performance Bonus Template)

Note: Emergency Department Utilization categories and criteria/deliverables are subject to change.

Background

Public Act 107 of 2013 105(d)(13) requires that ED utilization be included in the performance bonus. PA 107 calls for a symposium to examine the issues of ED utilization and provide best practice recommendations for reduction. To align with the symposium report expected to be released December 2014, ED utilization will be included as the focus bonus for FY16 and FY17.

ED Utilization Priority Statement

Many different factors influence an individual's decision to visit the ED. Emergency department (ED) utilization can tell insightful stories about quality and access issues in a community. Some factors, such as untreated emotional health concerns, or social circumstances that inhibit an individual's ability to attend to their health—such as housing, employment, or supportive relationships—often lie outside of the purview of managed care plans and their traditional provider networks. As a result, patients experience fragmentation or absence of care relative to their priorities. These unmet aspects of community life can lead to ED visits.

Care coordination, community partnerships, and collaboration between health plans are strategies that may increase access to more comprehensive services and improve health outcomes in an efficient way. Some examples of effective care coordination and collaboration models include contracting for Community Health Worker home visits in a community; partnering with community-based organizations such as social services, public health departments, mental health, housing, and transportation agencies; or collaborating with other health plans within a community or region to strengthen efforts.

Purpose

The purpose of the FY16 and FY17 ED Utilization Focus Bonus is to work with Plans through a process of: a) developing an in-depth understanding of ED Utilization relative to a Plan's population of interest; and b) designing interventions that move towards a more systematic approach to addressing complex issues that impact beneficiary utilization. Health Plans shall explore and develop a range of innovations and initiatives to improve the effectiveness and performance of ED utilization. Interventions should focus on high-volume, high-risk, or problem-prone areas; and acknowledge the clinical and non-clinical arenas of member life experience. Goals may include improvement in health outcomes; enhanced coordination of services and partnering with nontraditional healthcare providers; and increased cost-effectiveness with a major effort to lower overall ED Utilization in the State. The following forms have been designed to guide Plans through the process:

- **Baseline Analysis Form:** The purpose of the Baseline Analysis activity is to develop an in-depth understanding of ED Utilization that includes a review of literature (to include, if available, the Michigan ED Symposium Report); an initial ED utilization data analysis based on findings from the literature review; a plan to gather input from members who use the ED based on the data analysis; and a plan to identify barriers and gaps based on the data analysis and input from members.
- **Intervention Proposal Form:** The purpose of the Intervention Proposal activity is to develop interventions that target improvement in ED utilization based on findings from both a barrier and gap analysis and a partnerships scan. Plans will also be required to develop a plan for evaluating and improving interventions on an ongoing basis.
- **Intervention Reporting Form:** The purpose of the Intervention Report is to report the results of the intervention and ongoing assessments at 6 month intervals.

Submission and Scoring

There are three forms: 1) Baseline Analysis, 2) Intervention Proposal, and 3) Intervention Reporting. The forms have been designed to provide Plans with a general framework to guide their work through the FY16 and FY17 Focus Bonus, while also balancing the need for flexibility and autonomy that the complex issue of ED Utilization requires. Fill in the forms clearly and fully to receive points. There are two submission dates for the Baseline Analysis and the Intervention Proposal forms, as these submissions must be approved by MDCH. The first submission date allows Quality Improvement and Program Development (QIPD) Staff to review and provide feedback to the Plans, allowing revisions (if needed) before submitting for final approval on the

resubmission date. Submissions may be supplemented by additional documents such as reports, summaries, or tables. Supplemental documents should be sent along with submission forms as a ZIP file attachment.

Requesting guidance from the QIPD Section regarding planning, intervention, and analysis is encouraged. QIPD has several staff members with experience in qualitative and quantitative data collection and analysis, as well as program development relative to ED Utilization.

Plans will be scored on the basis of setting realistic and meaningful goals and benchmarks; and will be scored based on the extent to which they reach those goals and benchmarks. Questions or comments about submission and scoring may be directed to Sandra Greyerbiehl at greyerbiehls@michigan.gov.

ED Utilization Focus Bonus Timeline

FY 16 Deliverables	Deadlines	Points
A. BASELINE ANALYSIS FORM		
REPORTS COMPLETED by filling out Baseline Analysis Reporting Form Sections I. and II.: 1. Literature Review Report *(ED Symposium Report as 1 source)* (pg. 1) 2. Initial ED Visit Analysis Report (pg. 2)	First Submission: 3/15/2015	2 2
PLANS DEVELOPED by filling out Baseline Analysis Reporting Form Sections III. and IV.: 1. Plan for Gathering Input from Members (pg. 3) 2. Plan for Analyzing Barriers and Gaps (pg. 4)	Resubmission: 4/15/2015	3 3
Subtotal		**10**
B. INTERVENTION PROPOSAL FORM		
REPORTS COMPLETED by filling out the Intervention Proposal Form Sections I. and II.: 1. Barrier and Gap Analysis Report (pg. 1) 2. Partnership Scan Report (pg. 3)	First Submission: 8/15/2015	4 4
PLANS DEVELOPED by filling out Intervention Proposal Form Sections III. and IV.: 1. Plan for ED Utilization Interventions (pg. 5) 2. Plan for Ongoing Assessment (pg. 7)	Resubmission: 10/1/2015	6 6
Subtotal		**20**
C. INTERVENTION IMPLEMENTATION	2/15/2016	**5**
D. FY16 INTERVENTION REPORTING FORM		
REPORT COMPLETED by filling out the FY16 Intervention Reporting Form.	8/15/2016	**5**
FY 16 TOTAL		**40**
FY 17 Deliverables	**Deadlines**	**Points**
E. FY17 INTERVENTION REPORTING FORM		
REPORT COMPLETED by filling out the FY17 Intervention Reporting Form.	2/15/2017	**10**
F. FY17 INTERVENTION REPORTING FORM		
REPORT COMPLETED by filling out the FY17 Intervention Reporting Form.	8/15/2017	**30**
FY 17 TOTAL		**40**

APPENDIX 5d

Pay for Performance – Healthy Michigan Plan Cost-Sharing/Valued based Services

Note: Pay for Performance – Healthy Michigan Plan Cost-Sharing/Valued Based Services categories and criteria/deliverables are subject to change.

Cost-sharing is a key component of the Healthy Michigan Plan. Plans will develop systems and processes to appropriately implement the cost-sharing requirements of the HMP program. Baseline data on amounts collected will be established during FY2016, with standards set for FY2017.

Category	Description	Criteria/Deliverables
1. Cost Sharing and Incentives	Systems and processes related to cost sharing and incentives. There are several areas of review in this domain. • Informing providers and members of rights and responsibilities • Tracking and confirmation that incentives are applied as necessary • Vendor contracts and monitoring	1. February 15, 2016. Provider incentive. A Policy/Program Description will be submitted to DCH that outlines the MHP process for educating physicians on the Health Risk Assessment including the incentive program. 1. February 15, 2016. Member Incentive. a. A Policy/Program Description will be submitted to MDHHS that outlines the MHP process for members receiving an incentive. This will include, at a minimum, the following ▪ The process of receiving and processing completed Health Risk Assessments and identifying which members are eligible for incentives including HRAs completed during the FFS period ▪ The process to 'flag' those members for an incentive in the MIS/administrative system ▪ A congratulatory letter that is approved by MDHHS that informs members that they have earned an incentive and turnaround time for distribution of the letter and/or gift card. 2. Quarterly, MDHHS will randomly generate a list of member names for each plan based on information in the 5708 file. 1) Plans will provide documentation to confirm that each person below 100% FPL received a gift card. 2) Plans will use the Maximus portal to look up each person 100-133% FPL and confirm that the amount due reflects the requisite reduction. 3. February 15, 2016. Description of ongoing monitoring of Maximus in relation to a. Required reports: ▪ MI Health Account Statement File ▪ Detailed Payment File ▪ Summary Payment File This includes Participation in the quarterly oversight meetings with Maximus and description of processes to follow-up on issues identified during the course of oversight. b. Member education on cost-sharing responsibilities including welcome letter, statements, and payment coupons c. Investigation of MIHealth Account complaints received by Maximus
2. Value-based Services		**1.** March 15, 2016. Plans will submit a narrative description of how they encourage the use of high-value services and discourage the use of low-value services. This may include: a. Copay structure that: ▪ Eliminates copays for services and prescriptions related to chronic conditions ▪ Increases copays for non-emergent use of the emergency department

APPENDIX 5e
Performance Bonus
Integration of Behavioral Health and Physical Health Services

Note: Performance Bonus – Integration of Behavioral Health and Physical Health Services categories and criteria/deliverables are subject to change.

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-paid Inpatient Health Plans (PIHPs), the Department of Health and Human Services has developed the following joint expectations for both entities. This excludes beneficiaries seeking SUD services unless appropriate consent is obtained. Each plan (both PIHP and MHP) will submit a response for each criterion. There are 100 points possible for this initiative in FY2016.
FY2016 will be a process year working toward quantifiable results in FY2017. Separate and apart from the processes outlined below, FY2016 MDHHS will pull baseline data on the **Follow-up After Hospitalization for Mental Illness (FUH) measure for shared populations.** Baseline data will be published and a standard set for FY2017. If the processes below are successful, we would expect to see increases in this measure.

Category	Description	Criteria/Deliverables

1. **Identification of and Access to Data on Joint Members** (20 points)	Systems and processes related to regular, meaningful exchange of clinically relevant data between entities
	• Identification of Shared Members
	• Bi-directional Exchange (from Contract)
	• CC360
	  o Regular Reports
	  o Customizable Extracts
	• MiHIN
	  o Use Cases
	  o Active Care Relationship Service
	  o Admission, Discharge, Transfer (ADT) Messaging
		1. By March 1, 2016 PIHP and MHP will attend a meeting convened by MDHHS to discuss CC360 and MiHIN application and potential use as data sources
		2. By April 1, 2016 PIHP and MHP will submit policies/processes to demonstrate that they have systems and processes in place to confidentially do the following:
		  a. On a monthly basis, identify which members are assigned to an MHP and have sought services through the PIHP. This should include but is not limited to the following data elements (name, DOB, Medicaid ID number, providers seen, medications, diagnoses)
		  b. Receive information from electronic sources such as CC360 or HIT/HIE including:
		  ▪ Which reports are received at what interval including customizable extracts and how this information is shared between PIHP and MHP
		  c. Participate with MIHIN including:
		  ▪ Which Use Cases they are participating in
		  ▪ Active Care Relationships are being established for shared members
		  ▪ ADT messaging is being received and appropriately shared

2. **Development of Joint Care Management Standards and Processes** (30 points)	Appropriate communication exists and sufficient efforts are being made to support success in integration.	1. By July 1, 2016 plans will submit a narrative description of efforts to develop joint care management standards and processes including dates, attendees, and brief meeting notes to document that a minimum of three meetings took place between MHP and PIHP.

3. **Implementation of Joint Care Management Processes** (50 points)	Collaboration between entities for the ongoing coordination and integration of services	1. By September 1, 2016 MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities and have consented to a joint care plan. a. DHHS will generate a random list of members and share with both PIHP and MHP. Plans will submit the joint care plans to DHHS within the specified time frame. 2. By October 1, 2016 MHP and PIHP will submit a narrative description including dates, attendees, and examples of the diagnoses of members discussed to document attendance at monthly care management meetings.

APPENDIX 6

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care
Bright Futures/American Academy of Pediatrics

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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frequent counseling and treatment visits separate from preventive care visits.

Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																	
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																					
Weight for Length		●	●	●	●	●	●	●	●	●	●																						
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																	
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[7]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																	
Developmental Screening[9]								●			●		●																				
Autism Screening[10]											●	●																					
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																	
Newborn Blood Screening[15]		←	●	→																													
Critical Congenital Heart Defect Screening[16]		●																															
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★																
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	←	●	→	★	★	★	★	★	★	←		●	→
STI/HIV Screening[23]																						★	★	★	★	★	←	●	→	★	★	★
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and*

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. If the patient is uncooperative, rescreen within 6 months, per the 2007 AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/111/4/902.abstract).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-rus.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases.* Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Refer to a dental home, if available. If not available, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). If primary water source is deficient in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement "Preventive Oral Health Intervention for Pediatricians" (http://pediatrics.aappublications.org/content/122/6/1387.full) and 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full).

KEY □ = to be performed □ = risk assessment to be performed with appropriate action to follow, if positive □ = range during which a service may be provided

Summary of changes made to the
2014 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care
(Periodicity Schedule)

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment**- Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**- Screening for depression at ages 11 through 21 has been added, along with suggested screening tools. **Changes to Procedures**
- **Dyslipidemia screening**- An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**- A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**- A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled "STI Screening."
- **Cervical dysplasia**- Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease-** Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

For several recommendations, the AAP Policy has been updated since 2007 but there have been no changes in the timing of recommendations on the Periodicity Schedule. These include:

- Footnote 2- The Prenatal Visit (2009): http://pediatrics.aappublications.org/content/124/4/1227.full
- Footnote 4- Breastfeeding and the Use of Human Milk (2012): http://pediatrics.aappublications.org/content/129/3/e827.full and Hospital Stay for Healthy Term Newborns (2010): http://pediatrics.aappublications.org/content/125/2/405.full
- Footnote 8- Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs (2007): http://pediatrics.aappublications.org/content/120/4/898.full
- Footnote 10- Identification and Evaluation of Children with Autism Spectrum Disorders (2007): http://pediatrics.aappublications.org/content/120/5/1183.full
- Footnote 17- Immunization Schedules (2014): http://aapredbook.aappublications.org/site/resources/IZSchedule0-6yrs.pdf, http://aapredbook.aappublications.org/site/resources/IZSchedule7-18yrs.pdf, and http://aapredbook.aappublications.org/site/resources/IZScheduleCatchup.pdf
- Footnote 19- CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (2012): http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf
- Footnote 22- AAP-endorsed guideline "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (2011): http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm
- Footnote 25- Preventive Oral Health Intervention for Pediatricians (2008): http://pediatrics.aappublications.org/content/122/6/1387.full and Oral Health Risk Assessment Timing and Establishment of the Dental Home (2009): http://pediatrics.aappublications.org/content/111/5/1113.full. Additional information from the policies regarding fluoride supplementation and fluoride varnish has been added to the footnote.

New references were added for several footnotes, also with no change to recommendations in the Periodicity Schedule:

- Footnote 5- Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (2007): http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full
- Footnote 13- Use of Chaperones During the Physical Examination of the Pediatric Patient (2011): http://pediatrics.aappublications.org/content/127/5/991.full
- Footnote 15- The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/reco mmendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-rus.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

For consistency, the title of "Tuberculin Test" has been changed to "Tuberculosis Testing." The title of "Newborn Metabolic/Hemoglobin Screening" has been changed to "Newborn Blood Screening."

APPENDIX 7

MEDICAID MENTAL HEALTH SUBSTANCE USE DISORDER AUTHORIZATION AND PAYMENT RESPONSIBILITY GRID

Introduction:
The attached grid is designed to be used as a guide to assist Medicaid Health Plans and Prepaid Inpatient Health Plans in determining the responsible entity for authorization and payment of services. These are general guidelines and all Contractors should follow Medicaid policy as delineated in the Medicaid Provider Manual and in the Contractor's contract with the State.

Acronyms:
- DRG – Diagnosis-Related Group
- ED – Emergency Department
- I/DD - Intellectual/Developmental Disability
- MHA - Mental Health Assessment
- MHP - Medicaid Health Plan
- PAR - Pre-Admission Review
- PIHP - Prepaid Inpatient Health Plan (mental health and substance use disorder); in Wayne County, this includes the responsible Managed Care Provider Networks
- SMI - Serious Mental Illness
- SUD - Substance Use Disorder

Definitions:
Mental Health Assessment (MHA): Examination by a qualified mental health professional, typically in an in-patient acute care setting, to determine if a Pre-Admission Review or other mental health services are needed.

Pre-Admission Review (PAR): Michigan Department of Health and Human Services (MDHHS) requires a PAR for all individuals who may need inpatient mental health admission. A qualified mental health care professional screens the individual to determine if inpatient mental health care is appropriate and necessary. The PAR may be conducted telephonically or face-to-face by the PIHP.

Notes:
- Diagnosis may be ***one*** of the factors considered in determining the responsible entity but **is not** the only factor.
- Individuals with chronic mental illness who are stable may be appropriately treated within the 20-visit MHP outpatient mental health benefit.
- Post-psychiatric hospitalization crisis intervention is the responsibility of the PIHP.
- Specialty supports and services provided to individuals with an Intellectual/Developmental Disability, as outlined in the Medicaid Provider Manual, are the responsibility of the PIHP; mental health, physical health and substance use disorder services for these individuals are handled by the appropriate agency as designated below.

Type of Service Provided	Place of Service — Setting in Which Service is Provided					
	Mental Health Crisis Center - Access and Screening Center	Psychiatrist Social Worker/ Psychologist Outpatient Office	Inpatient Psychiatric Hospital Center	Inpatient Medical Acute Care Hospital	Medical Emergency Department	Outpatient Substance Abuse Office, Residential Substance Abuse Center or Sub-Acute Detox Center
Mental health services for individuals who have "mild to moderate" mental illness. NOTE: The authorization and payment responsibilities delineated for these individuals hold true regardless of whether the individual has concurrent I/DD or SUD.	Crisis intervention is the responsibility of the PIHP even if the individual is currently categorized as having "mild to moderate" mental illness. The PIHP is responsible for treating the individual until the individual is stabilized and no longer meets the criteria for serious mental illness treatment as outlined in Medicaid policy.	The MHP is responsible for a maximum of 20 mental health visits per calendar year; this service may or may not require authorization from the MHP. Typically, if the annual maximum 20-visit benefit has been exhausted, the beneficiary must wait until the next benefit renewal period in order to receive additional, routine outpatient mental health treatment. **	The PIHP's designated screening unit determines the need for inpatient mental health services. The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs, including psychiatrist-fees.	Mental health assessment while the individual is in an inpatient medical acute care hospital is the responsibility of the MHP; the MHP may require prior authorization. If the mental health assessment finds that screening for inpatient psychiatric hospital services is indicated, the PIHP should be contacted for PAR. Authorization and payment of the PAR is the responsibility of the PIHP.	After medical screening and stabilization, if a medical health professional believes that pre-screening for inpatient psychiatric hospital services is indicated, the ED should contact the PIHP for a PAR. The PAR may be conducted telephonically or face-to- face in the ED by the PIHP. Authorization and payment for PAR are the responsibility of the PIHP. Once the patient has been medically cleared, the medical health professional must contact the appropriate agency prior to any further mental health services. Contact the PIHP for PAR if the need for inpatient psychiatric services is suspected. If need for outpatient services is suspected, contact the PIHP.	The PIHP is responsible for payment. Mental health and SUD services should be coordinated with the MHP—this is especially true if the individual has co-occurring disorders (mental health and SUD). Refer to the document "Medicaid Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification" for information regarding acute care hospital inpatient medical detoxification.
	** THIS IS NOT AN MDHHS REQUIREMENT. However, some MHPs and PIHPs have chosen to use the following method: On a case-by-case basis, through discussion between the MHP and PIHP, mental health consultants concur that either:					

	1. additional treatment through the PIHP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition); or 2. additional treatment through the MHP may be provided to maintain the patient's mental health status until the next benefit year.					
Mental health services to Individuals who have "serious" mental illness. NOTE: The authorization and payment responsibilities delineated in this row hold true regardless if the individual has concurrent I/DD or SUD.	PIHP	PIHP	The PIHP designated pre-admission screening unit determines the need for inpatient mental health services and provides the authorization for inpatient admission as well as the associated professional fees.	Mental health assessment while the individual is in an inpatient medical acute care hospital is the responsibility of the MHP; the MHP may require prior authorization. If the mental health assessment finds that screening for inpatient psychiatric hospital services is indicated, the PIHP should be contacted for a PAR. Authorization and payment of the PAR is the responsibility of the PIHP.	After medical screening and stabilization, if a medical health professional believes that screening for inpatient psychiatric hospital services is indicated, the ED should contact the PIHP for PAR and authorization. The PAR may be conducted telephonically or face-to-face in the ED by the PIHP. Authorization and payment are the responsibility of the PIHP.	The PIHP is responsible for payment. Refer to the document "Medicaid Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification" for information regarding acute care hospital inpatient medical detoxification.
Treatment for Substance Use Disorder	PIHP	PIHP	N/A	Refer to the document "Medicaid Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification" for information regarding acute care hospital inpatient medical detoxification.	If necessary, ED staff may refer the patient to the PIHP for follow-up treatment. The MHP is responsible for hospital and professional services in the ED prior to medical stabilization. If the patient is admitted for acute medical detoxification, the ED costs are	The PIHP is responsible for payment.

					rolled into the inpatient DRG. Refer to the document "Medicaid Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification" for information regarding acute care hospital inpatient medical detoxification.	
Medical services to individuals enrolled with an MHP—Professional and Facility Services	N/A	N/A	MHP (may require authorization for non-emergent care)	MHP (may require authorization for non-emergent care)	MHP (may require authorization for post-stabilization treatment)	MHP (may require authorization for non-emergent care)
Diagnostic Tests (e.g., CT Scan, X-ray, Lab)	N/A	N/A	MHP (may require authorization for non-emergent care)	MHP (may require authorization for non-emergent care)	MHP (may require authorization for post-stabilization treatment)	MHP (may require authorization for non-emergent care)

APPENDIX 8
MEDICAID MENTAL HEALTH SUBSTANCE USE DISORDER INPATIENT MEDICAL ACUTE DETOXIFICATION

Inpatient Medical Acute Detoxification is the responsibility of the Michigan Department of Health and Human Services (MDHHS). Complete details on the policy covering this service can be found in the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of the Medicaid Provider Manual. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual >> Medicaid Provider Manual.

For admission to an acute care setting for a diagnosis of substance use disorder, the individual must meet at least one of the following criteria as reflected in the physician's orders and patient care plan. These criteria may be revised so it is important to refer to the Medicaid Provider Manual for current criteria list.

- Vital signs, extreme and unstable.
- Uncontrolled hypertension, extreme and unstable.
- Delirium tremens (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance use disorder. With pregnancy, monitoring the fetus is vital to the continued health of the fetus.
- Insulin-dependent diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an urgent/emergent condition.

Clarification of Inpatient Detox

- Acute medical detoxification services are reimbursed directly by Medicaid fee-for-service (FFS).
- The Medicaid Health Plan (MHP) is not responsible for substance use disorder services in any setting (inpatient or outpatient) which can include, but are not limited to, screening and assessments, detoxification of a substance, outpatient counseling or methadone treatment.
- Medicaid FFS covers inpatient hospitalization designed for the purpose of detoxification in an inpatient setting. The primary diagnosis on the claim must document that the hospitalization was for the sole purpose of providing an inpatient setting for detoxification. Medically necessary inpatient detoxification is only allowed under Medicaid policy in a life-threatening situation. Medicaid does not cover inpatient detoxification if the individual is not in a life-threatening situation or otherwise incapacitated.
- The MHP is not responsible for inpatient hospitalization if the individual is hospitalized due to the withdrawal of a substance of abuse (e.g., narcotics, alcohol, etc.). If detoxification has led to a life-threatening situation, MDHHS is responsible for the claim. Life-threatening situations are well defined in the Medicaid Provider Manual in the Hospital chapter.
- The MHP covers inpatient hospitalization if the individual is hospitalized for medical complications caused by substance use disorder. In these cases, the primary diagnosis must reflect the medical problem for which the individual was admitted. Substance use disorder may appear as a diagnosis other than primary; however, the existence of substance use disorder as a diagnosis other than primary does not render the hospitalization payable by Medicaid FFS.
- Authorization is required for all inpatient admissions for medical conditions.

APPENDIX 9
PREPAID INPATIENT HEALTH PLAN – MEDICAID HEALTH PLAN MODEL AGREEMENT

PIHP-MHP Model Agreement

Coordinating Agreement Between
<PIHP> and <MHP> For the county(ies) of:
<X>

<DATE>

This agreement is made and entered into this ___ day of _____, in the year ____ by and between _____ (Health Plan) and _____ (PIHP) for the county(ies) of X, Y, Z.

RECITALS

Whereas, PIHPs are designated as providers of specialized mental health and developmental disability services under contract with the MDHHS consistent with the Mental Health Code; and

Whereas, PIHPs manage the Medicaid Specialty Services and Supports in a specified geographic region; and

Whereas, MHPs and PIHPs desire to coordinate and collaborate their efforts in order to protect and promote the health of the shared Medicaid-enrolled population;

Now, therefore, the MHP and the PIHP agree as follows.

A. Definitions

"MDHHS" means the Michigan Department of Health and Human Services.

"MHP" means Medicaid (Medical) Health Plan.

"PCP" means Primary Care Physician/Practitioner.

"PIHP" means Prepaid Inpatient Health Plan.

B. Roles and Responsibilities

The parties acknowledge that the primary guidance concerning their respective roles and responsibilities stem from the following, as applicable:

- Medicaid Waivers
- Medicaid State Plan and Amendments
- Medicaid Manual
- MDHHS, MHP and PIHP Contracts.
- Medical Services Administration (MSA) Medicaid *L-Letter 10-21* http://www.michigan.gov/documents/mdch/L_10- 21_with_attachment_322809_7.pdf

C. Term of Agreement, Amendments and Cancellation

This Agreement is effective the date upon which the last party signs this Agreement until amended or cancelled. The Agreement is subject to amendment due to changes in the contracts between the MDHHS and the MHP or the PIHP. All Amendments shall be executed in writing. Either party may cancel the agreement upon thirty (30) days written notice.

D. Purpose, Administration and Point of Authority

The purpose of this Agreement is to address the integration of physical and mental health services provided by the MHP and PIHP for common Medicaid enrollees. Specifically, to improve Medicaid enrollee's health status, improve the Medicaid enrollee's experience of care, and to reduce unnecessary costs.

The MHP and PIHP designate below the respective persons who have authority to administer this Agreement on behalf of the MHP and PIHP:

<MHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

<PIHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

E. Areas of Shared Responsibility

1. Exchange of Information

a. Each party shall inform the other of current contact information for their respective Medicaid enrollee Service Departments.

b. MHP shall make electronically available to the PIHP its enrolled common/shared Medicaid enrollee list together with their enrolled Medicaid enrollee's PCP and PCP contact information, on a monthly basis.

c. The parties shall explore the prudence and cost-benefits of Medicaid enrollee information exchange efforts. If Protected and/or Confidential Medicaid enrollee Information are to be exchanged, such exchanges shall be in accordance with all applicable federal and state statutes and regulations.

d. The parties shall encourage and support their staff, PCPs and provider networks in maintaining integrative communication regarding mutually served Medicaid enrollees.

e. Prior to exchanging any Medicaid enrollee information, the parties shall obtain a release from the Medicaid enrollee, as required by federal and/or state law.

2. Referral Procedures

a. The PIHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the MHP and how to contact the MHP. The PIHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a PCP.

b. The MHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the PIHP and how to contact the PIHP. The MHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a PCP.

c. Each party shall exercise reasonable efforts to rapidly determine and provide the appropriate type, amount, scope and duration of medically necessary services as guided by the Medicaid Manual.

3. Medical and Care Coordination; Emergency Services; Pharmacy and Laboratory Services Coordination; Quality Assurance Coordination

a. Each party shall exercise reasonable efforts to support Medicaid enrollee and systemic coordination of care. The parties shall explore and consider the prudence and cost-benefits of systemic and Medicaid enrollee focused care coordination efforts. If care coordination efforts involve the exchange of Medicaid enrollees' health information, the exchange shall be in accordance with applicable federal and state statutes and regulations related thereto. Each shall make available to the other contact information for case level medical and care coordination.

b. Neither party shall withhold emergency services and each shall resolve payment disputes in good faith.

c. Each party shall take steps to reduce duplicative pharmacy and laboratory services and agree to abide by L-Letter 10-21 and other related guidance for payment purposes.

d. Each party agrees to consider and may implement by mutual agreement Quality Assurance Coordination efforts.

F. Grievance and Appeal Resolution

Each agrees to fulfill its Medicaid enrollee rights and protections grievance and appeal obligations with Medicaid enrollees, and to coordinate resolutions as necessary and appropriate.

G. Dispute Resolution

The parties specify below the steps that each shall follow to dispute a decision or action by the other party related to this Agreement:

1) Submission of a written request to the other party's Agreement Administrator for reconsideration of the disputed decision or action. The submission shall reference the applicable Agreement section(s), known related facts, argument(s) and proposed resolution/remedy; and

2) In the event this process does not resolve the dispute, either party may appeal to their applicable MDHHS Administration Contract Section representative.

Where the dispute affects a Medicaid enrollee's current care, good faith efforts will be made to resolve the dispute with all due haste and the receiving party shall respond in writing within three (3) business days.

Where the dispute is in regards to an administrative or retrospective matter the receiving party shall respond in writing within thirty (30) business days.

H. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all applicable federal, state, and local statutes and regulations. Where federal or state statute, regulation or policy is contrary to the terms and conditions herein, statute, regulation and policy shall prevail without necessity of amendment to this Agreement.

I. Merger and Integration

This Agreement expresses the final understanding of the parties regarding the obligations and commitments which are set forth herein, and supersedes all prior and contemporaneous negotiations, discussions, understandings, and agreements between them relating to the services, representations and duties which are articulated in this Agreement.

J. Notices

All notices or other communications authorized or required under this Agreement shall be given in writing, either by personal delivery or by certified mail (return receipt requested). A notice to the parties shall be deemed given upon delivery or by certified mail directed to the addresses shown below.

Address of the PIHP:

_____

_____

_____

Attention: _____

Address of the MHP:

_____

_____

_____

Attention: _____

K. Headings

The headings contained in this Agreement have been inserted and used solely for ease of reference and shall not be considered in the interpretation or construction of this Agreement.

L. Severability

In the event any provision of this Agreement, in whole or in part (or the application of any provision to a specific situation) is held to be invalid or unenforceable, such provision shall, if possible, be deemed written and revised in a manner which eliminates the offending language but maintains the overall intent of the Agreement. However, if that is not possible, the offending language shall be deemed removed with the Agreement otherwise remaining in effect, so long as doing so would not result in substantial unfairness or injustice to either of the parties. Otherwise, the party adversely affected may terminate the Agreement immediately.

M. No Third Party Rights

Nothing in this Agreement, express or implied, is intended to or shall be construed to confer upon, or to give to, any person or organization other than the parties any right, remedy or claim under this Agreement as a third party beneficiary.

N. Assignment

This Agreement shall not be assigned by any party without the prior written consent of the other party.

O. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute the one in the same instrument.

P. Signatures

The parties by and through their duly authorized representatives have executed and delivered this Agreement. Each person signing this Agreement on behalf of a party represents that he or she has full authority to execute and deliver this Agreement on behalf of that party with the effect of binding the party.

IN WITNESS WHEREOF, the parties hereto have entered into, executed, and delivered this Agreement as of the day and year first written above.

PIHP

By: _____

Its:_____

Date:_____

MHP

By: _____

Its:_____

Date:_____

APPENDIX 10
HIPAA BUSINESS ASSOCIATE AGREEMENT ADDENDUM

This Business Associate Agreement Addendum ("Addendum") is made a part of the contract ("Contract") between the Michigan Department of Health and Human Services ("Covered Entity"), and _____, ("Business Associate").

The Business Associate performs certain services for the Covered Entity under the Contract that requires the exchange of information including protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub.L. No. 111-5). The Michigan Department of Health and Human Services is a hybrid covered entity under HIPAA and the parties to the Contract are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and have the underlying Contract comply with HIPAA.

RECITALS

A. Under the terms of the Contract, the Covered Entity wishes to disclose certain information to the Business Associate, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, the Business Associate agrees to protect the privacy and security of the information as set forth in this Addendum.

B. The Covered Entity and the Business Associate intend to protect the privacy and provide for the security of PHI disclosed to the Business Associate under the Contract in compliance with HIPAA and the HIPAA Rules.

C. The HIPAA Rules require the Covered Entity to enter into a contract containing specific requirements with the Business Associate before the Covered Entity may disclose PHI to the Business Associate.

1. Definitions.

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

b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103 and regarding this Addendum means [Insert Name of Business Associate]

c. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this Addendum means the Michigan Department of Health and Human Services.

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

e. "Agreement" means both the Contract and this Addendum.

f. "Contract" means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added.

2. Obligations of Business Associate.

The Business Associate agrees to

a. use and disclose PHI only as permitted or required by this Addendum or as required by law.

b. implement and use appropriate safeguards, and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Addendum. Business Associate must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of the Business Associate's operations and the nature and the scope of its activities.

c. report to the Covered Entity within 24 hours of any use or disclosure of PHI not provided for by this Addendum of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If the Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and the Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

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

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

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under 45 CFR § 164.526. If any individual requests an amendment of PHI directly from the Business Associate or its agents or subcontractors, the Business Associate must notify the Covered Entity in writing within ten days of the request, and then, in that case, only the Covered Entity may either grant or deny the request.

g. maintain, and within ten days of a request from the Covered Entity make available the information required to enable the Covered Entity to fulfill its obligations under 45 CFR § 164.528. Business Associate is not required to provide an accounting to the Covered Entity of disclosures : (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes as set forth in 45 CFR § 164.512(k)(2); or (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by the Business Associate and its agents or subcontractors for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of

purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. If the request for an accounting is delivered directly to the Business Associate or its agents or subcontractors, the Business Associate must forward it within ten days of the receipt of the request to the Covered Entity in writing.

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

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

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

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

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

3. Permitted Uses and Disclosures by the Business Associate.

a. Business Associate may use or disclose PHI:

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

(ii) as required by law;

(iii) for Data Aggregation services relating to the health care operations of the Covered Entity;

(iv) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

(v) for any other purpose listed here: carrying out the Business Associate's duties under the Contract.

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

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

4. Covered Entity's Obligations

Covered entity agrees to

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

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

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

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

5. Term. This Addendum must continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by the Business Associate of any provision of this Addendum, as determined by the Covered Entity, constitutes a material breach of the Addendum and is grounds for termination of the Contract by the Covered Entity under the provisions of the Contract covering termination for cause. If the Contract contains no express provisions regarding termination for cause, the following apply to termination for breach of this Addendum, subject to 6.b.:

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

(ii) Associate's Duties. Notwithstanding termination of the Contract, and subject to any directions from the Covered Entity, the Business Associate must timely, reasonably and necessarily act to protect and preserve property in the possession of the Business Associate in which the Covered Entity has an interest.

(iii) Compensation. Payment for completed performance delivered and accepted by the Covered Entity must be at the Contract price.

(iv) Erroneous Termination for Default. If the Covered Entity terminates the Contract under Section 6(a) and after such termination it is determined, for any reason, that the Business Associate was not in default, or that the Business Associate's action/inaction was excusable, such termination will be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Contract had been terminated for convenience.

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

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

(i) retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
(ii) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;
(iii) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Business Associate retains the PHI;
(iv) not use or disclose the PHI retained by the Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and
(v) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by the Business Associate when it is no longer needed by the Business Associate for its proper management and administration or to carry out its legal responsibilities.

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

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

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

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

11. Amendment.

a. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA and the HIPAA Rules. Either party may terminate the Agreement upon thirty days written notice if (i) the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Covered Entity under this Section or (ii) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Rules.

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

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

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract must remain in force and effect. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Business Associate and the Covered Entity expressly waive any claim or defense that this Addendum is not part of the Contract.

15. Interpretation and Order of Precedence. This Addendum is incorporated into and becomes part of the Contract. Together, this Addendum and each separate Contract constitute the "Agreement" of the parties with respect to their Business Associate relationship under HIPAA and the HIPAA Rules. The provisions of this Addendum must prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract must be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Rules. The parties agree that any ambiguity in this Addendum must be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Rules. This Addendum supersedes and replaces any previous separately executed HIPAA addendum between the parties. If this Addendum conflicts with the mandatory provisions of the HIPAA Rules, then the HIPAA Rules control. Where the provisions of this Addendum differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Addendum control.

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

17. Survival of Certain Contract Terms. Notwithstanding anything in this Addendum to the contrary, the Business Associate's obligations under Section 6(d) and record retention laws ("Effect of Termination") and Section 13 ("No Third Party Beneficiaries") survive termination of this Addendum and are enforceable by the Covered Entity if the Business Associate fails to perform or comply with this Addendum.

18. Representatives and Notice.

a. Representatives. For the purpose of this Addendum, the individuals identified in the Contract must be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are designated as the parties' respective representatives for purposes of this Addendum. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices must be in writing and must be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

Name: Kim Stephen
Title: Director
Department and Division: Michigan Department of Health and Human Services
Bureau of Budget and Purchasing
Address: 320 S. Walnut Street
Lansing, MI 48913

Business Associate Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____
_____
_____

Any notice given to a party under this Addendum must be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third (3rd) Business Day after being sent by certified or registered mail.

Business Associate	**Covered Entity**
[INSERT NAME]	Michigan Department of Health and Human Services
By:_____	By:_____
Date:_____	Date: _____
Print Name: _____	Print Name: Kim Stephen
Title:_____	Title: Director, Bureau of Budget and Purchasing

APPENDIX 11
STATE LABORATORY SERVICES

Test	Current Procedure Terminology (CPT) Code
Chlamydia Nucleic Acid Amplification Test (NAAT)	87491
Gonorrhea NAAT	87591
Hepatitis B	86706, 87340
Hepatitis C	86803, 86804
Herpes Culture	87274, 87273
Syphilis serology	87164
Fungal identification	87107, 87101, 87102
Yeast identification	87106
Ova and Parasite	87169, 87172, 87177, 87206, 87207, 87209
Bacterial identification	87077, 87076
Mycobacteria culture	87116, 87015, 87206
M. tuberculosis Amplified Probe	87556
Blood lead	83655
Trichomonas NAAT	87661

APPENDIX 12
SUBCONTRACTOR TEMPLATE

2.2: Provider Subcontractors
Contract Authority: 2.3 I(A, B)

MHP:

For more than 2 subcontractors per category duplicate page(s)

Due Date: January 15

Category I Health Benefit Manager	**Notify MDHHS 30 days prior to effective date**
Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	
Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	
Category II Administrative A, B or C	**Notify MDHHS within 21 days of the effective date**
Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	
Category III Transportation	**Type A Notify MDHHS 30 days prior to effective date Type B Notify MDHHS within 21 days of the effective date**
Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Transportation Type A or B Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	
Full Name of Subcontractor	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Subcontractor Type A or B Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

APPENDIX 13

Contractor's Awarded Rates

The State of Michigan Managed Care Rates will be paid within the certified, actuarially sound rate range. Fiscal Year 2016 Managed Care Rates are effective from January 1, 2016 through September 30, 2016.

Subsequent Fiscal Years under this contract will have twelve-month rate-setting periods from October 1 through September 30 of the respective Fiscal Year which correspond to the contract year. If rates require recertification during the contract year, a contract amendment will be issued. Rates will be distributed under a separate cover and are incorporated herein by reference.