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

Table of Contents

Standard Contract Terms **4**
Federal Provisions Addendum **21**
Exhibit A: Statement of Work 23
1.0 Specifications **25**
1.1 Contractor Requirements **25**
I. Service Area **25**
II. Medicaid Eligibility and CHCP Enrollment Groups **26**
III. Payment Reform **28**
IV. CHCP Enrollment and Disenrollment **29**
V. Access and Availability **34**
VI. Covered Services **47**
VII. Coordination for Services Covered Outside of this Contract **61**
VIII. Behavioral Health Integration **62**
IX. Patient-Centered Medial Home Expansion and Coordination with Accountable Systems of Care **64**
X. Population Health Management **64**
XI. Quality Improvement and Program Development **72**
XII. Cost-Sharing Requirements **80**
XIII. Enrollee Services **81**
XIV. Provider Services **96**
XV. Management Information Services **102**
XVI. Health Information Exchange/Health Information Technology **104**
XVII. Observance of State and Federal Laws and Regulations **105**
XVIII. Program Integrity **113**
2.0 Personnel, Organizational Structure, Governing Body and Subcontractors **131**
2.1 Personnel, Organizational Structure, and Governing Body **131**
2.2 Disclosure of Subcontractors **136**

2.3 Subcontractor Classifications and Flow-down 136
3.0 Project Management 139
3.1 Meetings 139
3.2 Reporting 139
4.0 Payment and Taxes 143
4.1 Payment Terms 143
4.2 Taxes 145
5.0 Health Insurance Portability and Accountability Act (HIPAA) 146
5.1 HIPAA Business Associate Agreement Addendum 146
Definitions 147

List of Appendices

Appendix 1: Rural Area Exceptions Counties 157
Appendix 2: MDHHS Financial Monitoring Standards 158
Appendix 3: Reporting Requirements for Medicaid Health Plans 159
Appendix 4: Performance Monitoring Standards 161
Appendix 5a: Performance Bonus Template 169
Appendix 5b: Pay for Performance on Population Health and Health Equity 173
Appendix 5c: Focus Bonus-Emergency Department Utilization 179
Appendix 5d Pay for Performance-Healthy Michigan Plan Cost-Sharing/Value Based Services 182
Appendix 5e: Performance Bonus-Integration of Behavioral Health and Physical Health Services 187
Appendix 5f: Alternative Payment Model (APM) Pay for Performance Bonus Program 188
Appendix 5g: Encounter Quality Initiative (EQI) Requirements for Medicaid Health Plans . 191
Appendix 6: Recommendations for Preventive Pediatric Health Care 192
Appendix 7: Medicaid Mental Health Substance Use Disorder Authorization and Payment Responsibility Grid 194
Appendix 8: Medicaid Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification 198
Appendix 9: Prepaid Inpatient Health Plan-MHP Model Agreement 199
Appendix 10: HIPAA Business Associate Agreement Addendum 204
Appendix 11: State Laboratory Services 213
Appendix 12: Subcontractor Template 214
Appendix 13: Contractor's Awarded Rates 217

Appendix 14: Medicaid Health Plan Provider Network Standards 218
Appendix 15: Appointment and Timely Access to Care Standard 219
Appendix 16: Provider Directory Listing Requirements 220
Appendix 17:Reserved 221
Appendix 18: Compliance Review Program Integrity.....222

STATE OF MICHIGAN

STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and Input name ("**Contractor**"), a Michigan Company [Insert State & Entity Status, *e.g.*, a Michigan corporation or a Texas limited liability company]. 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*	*[Name]* *[Street Address]* *[City, State, Zip]* *[Email]* *[Phone]*

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*	*[Name]* *[Street Address]* *[City, State, Zip]* *[Email]* *[Phone]*

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

State:	Contractor:
Sharene Johnson (day-to-day) *Michigan Department of Health and Human Services* *Capitol Commons Center* *400 South Pine* *Lansing, MI, 48933* *JohnsonS14@michigan.gov* *Phone: (517) 241-7933*	*[Name]* *[Street Address]* *[City, State, Zip]* *[Email]* *[Phone]*

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*	*[Name]* *[Street Address]* *[City, State, Zip]* *[Email]* *[Phone]*

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 a 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	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies,

$2,000,000 General Aggregate $2,000,000 Products/Completed Operations <u>Deductible Maximum:</u> $50,000 Per Occurrence	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	
<u>Minimal Limits:</u> Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
<u>Minimal Limits:</u> $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
<u>Minimal Limits:</u> $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	
<u>Minimal Limits:</u> $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	
<u>Minimal Limits:</u> $3,000,000 Each Occurrence $3,000,000 Annual Aggregate <u>Deductible Maximum:</u> $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.

   Contractor must comply with all Subcontractor requirements under this Contract as described in Section 2.3 Subcontractor Requirements, Classifications and Flowdown.

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 10 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*., and Executive Directive 2019-09. 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 (as defined in Executive Directive 2019-09), height, weight, marital status, partisan considerations, any mental or physical disability or genetic information that is unrelated to the person's ability to perform the duties of a particular job or position. 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**").

Federal Provisions Addendum

The provisions in this addendum may apply if the purchase will be paid for in whole or in part with funds obtained from the federal government. If any provision below is not required by federal law for this Contract, then it does not apply and must be disregarded. If any provision below is required to be included in this Contract by federal law, then the applicable provision applies and the language is not negotiable. If any provision below conflicts with the State's terms and conditions, including any attachments, schedules, or exhibits to the State's Contract, the provisions below take priority to the extent a provision is required by federal law; otherwise, the order of precedence set forth in the Contract applies. Hyperlinks are provided for convenience only; broken hyperlinks will not relieve Contractor from compliance with the law.

1. Reserved.

2. Reserved.

3. Copeland "Anti-Kickback" Act

If applicable, the Contractor must comply with the Copeland "Anti-Kickback" Act (40 USC 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"), which prohibits the Contractor and subrecipients from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled

4. Reserved.

5. Rights to Inventions Made Under a Contract or Agreement

If the Contract is funded by a federal "funding agreement" as defined under 37 CFR §401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

6. Clean Air Act

If this Contract is **in excess of $150,000,** the Contractor must comply with all applicable standards, orders, and regulations issued under the Clean Air Act (42 USC 7401-7671q) and the Federal Water Pollution Control Act (33 USC 1251-1387). Violations must be reported to the federal awarding agency and the regional office of the Environmental Protection Agency.

7. Debarment and Suspension

A "contract award" (see 2 CFR 180.220) must not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

8. Byrd Anti-Lobbying Amendment

If this Contract **exceeds $100,000**, bidders and the Contractor must file the certification required under 31 USC 1352.

9. Procurement of Recovered Materials

Under 2 CFR 200.322, a non-Federal entity that is a state agency or agency of a political subdivision of a state **and its contractors** must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring

only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded

$10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

STATE OF MICHIGAN

Contract No.
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 this Contract. The term "Contractor" in this document refers to.

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.

Contractor 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.

Contractor must fully participate with MDHHS-directed payment reform initiatives implemented throughout the term of the Contract and the expansion of patient-centered medical homes. Contractor 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. Regions

Contractor must operate in one or more of 10 Regions throughout the State for the provision of Covered Services. Contractor must provide evidence of network adequacy to MDHHS upon request and as required in this Contract. Regions are defined and numbered 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

The Contractor's Service Area includes all Regions identified by MDHHS as a Region in which Members may be enrolled in the Contractor's MHP. Expansion of, or changes to, the Contractor's Service Area will be at the sole discretion of MDHHS.

C. Contiguous County Service Areas

Contractor may provide services in their Contracted Service Area through the use of Network Providers 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 Network Provider and the counties in the Region to be served through this Network Provider.

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 in the 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 (PCP).
        i. Contractor may not limit an Enrollee's freedom to change between PCPs without cause in a manner that is more restrictive than the limitations that apply to Enrollee disenrollment from a MHP under this Contract.
    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 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 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 may be 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. Persons 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 (HMP)

   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 Individuals with Intellectual Disability (ICF/ID) 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 dis-enrolled 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

3. Contractor will report at least semi-annually to MDHHS on MHP health care services reimbursed under value-based payments using the format specified by MDHHS in Appendix 5f, and will comply with payment reform goals and threshold targets established by MDHHS in consultation with contracted MHPs.

B. Patient-Centered Medical Homes

1. Contractor must share data and exchanging health information with capable PCMHs in their provider network.

2. Contractor must contract with providers in their network to provide care management and care coordination services to their members with contracts effective January 1, 2020.

3. Contractor must encourage providers in their network to become PCMH certified, and prioritize the assignment of members to PCMH practices.

4. Contractor must coordinate health plan care management activities and care managers with care management and coordination activities and staff embedded in participating practices, and
5. Contractor must utilize the PCMH model within their APM strategy consistent with Appendix 5f.
6. Contractor must make payments based on the Primary Care Provider selected by or assigned to each Medicaid Enrollee (as determined by the Contractor and communicated to MDHHS), or to the physician organization of that Primary Care Provider, as instructed by MDHHS for the first quarter only.

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, national origin, age, disability, sex, or other factors identified in 42 CFR 438.3(d) 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. Contractor 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 all 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 retroactively 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. Contractor 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 or during the 90 days following notification of enrollment, whichever is later, 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 any 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:
    3. 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
    4. 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 will 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. With the exception of newborns, 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. Adverse change in physical or mental health status
    b. Utilization of medical services
    c. Diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued

enrollment seriously impairs the entity's ability to furnish services to either this particular Enrollee or other Enrollees.)

J. Special Disenrollments

1. Contractor may initiate special disenrollment requests to MDHHS if the Enrollee acts in a violent or threatening manner not resulting from the Enrollee's special needs as prohibited in the Disenrollment Discrimination section of the Contract. 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.
5. Contractor is prohibited from requesting disenrollment of an Enrollee for reasons other than those permitted in this Contract.

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 (UM) 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. The facility must be enrolled in the Medicaid program before disenrollment can take place.
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" orally or in writing 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. The Enrollee moves out of the Contractor's service area.
    b. Enrollee's current Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks.
    c. 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.
    d. 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 Out-of-Network providers approved by the Contractor.
    e. 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.
4. Enrollee may request disenrollment from the Contractor if the State imposes an intermediate sanction in which all new enrollment including default enrollment has

been suspended from the Contractor for violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

5. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Enrollee requests disenrollment. If the State fails to make a determination within this timeframe, the disenrollment is considered approved for the effective date that would have been established had the State complied with the required timeframe.

O. Dental Service Enrollment for non-HMP Pregnant Beneficiaries

1. MDHHS will pay Contractor an enhanced Maternity Case Rate for all non-HMP Enrollees including CSHCS beneficiaries for the provision of dental services.
2. Pregnant beneficiaries enrolled in Healthy Kids Dental (HKD) will continue to receive services through HKD and are excluded.
3. Contractor must administer covered dental services through the Contractor's managed care structure.
4. Pregnant non-HMP Enrollees are eligible to access covered dental services.
5. Contractor must provide dental services for pregnant non-HMP Enrollees when:
   a. MDHHS indicates Enrollee access to dental services via the pregnancy due date listed in the HIPAA-compliant enrollment files.
   b. Contractor becomes aware of Enrollee's pregnancy via Enrollee's claims data or Enrollee notification to Contractor.
      i. If Contractor becomes aware of Enrollee's pregnancy prior to MDHHS notification, Contractor must notify MDHHS of Enrollee's pregnancy utilizing the appropriate MDHHS notification form.
6. Contractor must notify its dental vendor of Enrollee's eligibility for covered dental services.
7. Coverage for managed care dental service begins on the first day of the same month that the Contractor becomes aware of the Enrollee's pregnancy as specified in section IV.O.5 of this contract.
8. Coverage for managed care dental services ends on the last day of the third calendar month, after the end of beneficiary's pregnancy. Contractor must calculate the coverage period using the calculation in this section (IV.O)

V. Access and Availability of Providers and Services

A. Network Requirements

1. Contractor must maintain and monitor a network of Medicaid enrolled, 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 supported by written agreements and sufficient to provide adequate access to all Covered Services for the maximum number of Enrollees specified under this Contract including those with limited English proficiency, deaf or hard of hearing, or physical or mental disabilities, CSHCS Enrollees and Persons with Special Health Care Needs and must submit documentation to MDHHS to that effect. Adequate access to Covered Services includes compliance with federal regulations at 42 CFR 438 and this Contract.
   a. Contractor must make Covered Services available 24 hours a day, seven days a week, when Medically Necessary.

b. Contractor must ensure PCP services, OB/GYN, hospital services, pharmacy, outpatient behavioral health and other services identified in Appendix 14 are available from Network Providers within the specified travel distance and time requirements from the Enrollee's home. Exceptions, if any, to these time and distance standards will be at the discretion of MDHHS and only considered based on the number of Providers practicing in the identified specialty participating in the MHP service area and other criteria specified in Appendix 14.

i. If an exception to a time or distance standard is granted by MDHHS, the exception is limited to the identified provider type and county or counties and is granted for a period of up to one year.

ii. As part of its Network Access Plan as described in Section V.A. 15:

(ii)i Contractor must develop a plan describing how it will reasonably deliver Covered Services to Enrollees who may be affected by the exception and how Contractor will work to increase access to the provider type in the designated county or counties.

(ii)ii Contractor must monitor, track and report to MDHHS the delivery of Covered Services to Enrollees potentially affected by the exception.

c. Contractor must meet and require its Network Providers to meet MDHHS standards for timely access to care and services under this Contract, including standards identified in Appendix 15, and taking into account the urgency of the need for services.

d. Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid Enrollees with physical or mental disabilities.

e. Contractor must establish mechanisms to ensure Network Providers compliance with standards in this Contract, including monitoring Network Providers regularly to determine compliance and taking corrective action if there is a failure to comply by a Network Provider.

f. Contractor must notify Enrollee of MDHHS' published network adequacy standards and provide a printed copy of the network adequacy standards to Enrollees upon request. Delivery method of the printed copy will be determined by the Enrollee's request.

3. Contractor must ensure contracted PCPs have a system to provide or arrange for coverage of services 24 hours per day, seven days per week when Medically Necessary. Contractor must ensure that its PCPs comply with the access and availability requirements in this Contract.

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 (PSHCN) 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 500 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 ordinarily used by the Medicaid population and whether the Provider Network locations provide access for Enrollees with physical or developmental disabilities.
11. Contractor must participate in 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), diverse cultural and ethnic backgrounds, disabilities, and regardless of gender or other factors in accordance with 438.206(c)(2).
12. 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.
13. Contractor must arrange for laboratory services through laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.
14. Contractor must ensure female Enrollees are provided access to a women's health specialist within the Provider Network to provide for women's necessary preventive and routine health care services. This is in addition to the Enrollee's designated PCP if that Provider is not a women's health specialist.
15. Contractor must offer adequate access to NEMT services for its Enrollee demand in accordance with section VI.H.(4)(c) of this contract.
16. Contractor must attest to and demonstrate compliance with contractual network adequacy and timeliness to care requirements on at least an annual basis. Contractor must develop, submit and comply with a Network Access Plan which describes its network development and network management activities and results. The report must include any findings of Provider non-compliance and any corrective action plan and/or measures taken by the Contractor to bring the Provider into compliance.
    a. The Network Adequacy Plan must demonstrate that the Contractor:
        i. Offers an appropriate range of preventive, primary care, specialty, NEMT and dental services that is adequate for the anticipated number of Enrollees for the service area
        ii. Maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area.

iii. Monitors and acts on changes or gaps in Provider Network including exceptions, if any, granted by MDHHS to travel standards, including how the Contractor monitors exceptions, addresses network gaps and improves access and availability to health services across Regions and provider specialties.

b. Contractor's Network Access Plan at a minimum must contain the following:

i. A description of the Contractor's network, criteria used to select Providers, and the Contractor's process for reviewing, updating, and submitting its Provider Directory consistent with this Contract.

ii. Geo access time and distance tables in the format specified by MDHHS of adult and pediatric PCPs, outpatient Behavioral Health, OB/GYN, Specialists, Dentists and Pharmacy. Provider coverage demonstrating compliance with time and distance standards in Appendix 14 for Enrollees and Potential Enrollees in Contractor's Service Area. Providers that are not accepting new patients, including Providers with some conditions on accepting new patients must be excluded from geo-access time and distance tables. Additional time and distance tables of all providers, including those not accepting new patients, may be submitted.

iii. Contractor's process for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the health care needs of Enrollees for all Covered Services within MDHHS' network adequacy and timely access standards including:

(iii)i PCPs not accepting new patients and how the Contractor will work to increase the number and percentage of network PCPs accepting new patients without conditions/limitations.

(iii)ii Methods for accessing health care needs of Enrollees and their satisfaction with access to and availability of Covered Services.

(iii)iii Provider ratios, surveys, analysis and other information to demonstrate Contractor's ability to meet MDHHS' network adequacy and time and distance standards including those in Appendix 14 and Appendix 15.

(iii)iv Availability of telemedicine or telehealth, e-visits, triage lines or screening systems or other technology used to enhance access to care.

(iii)v Contractor's Rural service area strategies to maximize healthcare network access and availability for Enrollees.

(iii)vi Contractor's procedures and time frames for making and authorizing referrals and prior authorizations if applicable within and outside its network.

(iii)vii Contractor's efforts to ensure that its Provider Network addresses the needs of Enrollees, including but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex, medical conditions.

(iii)viii Contractor's plan for providing continuity of care in the event of new population enrollment, changes in service area, covered benefits, contract termination between the Contractor and any of its participating Providers including major health care groups, Contractor insolvency or other inability to continue operations.

(iii)ix How the Contractor will address and improve access and availability in network gaps for Provider specialty exceptions granted by DHHS, if applicable. Contractor must provide a report at the end of the fiscal contract year of Enrollee access to affected health services in area(s) where Contractor has been granted an exception to time or distance standards by MDHHS.

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, including modifications to its Network Access Plan, if:
    a. There are changes in services, benefits, service area, or payments
    b. A new population is enrolled
4. Contractor must make a good faith effort to give written notice of termination of a Network Provider within 15 Days after receipt or issuance of the termination notice to each Enrollee who received primary care from, or was seen on a regular basis by, the terminated Provider.

C. Access to Care and Standards for Timeliness of Appointments

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.

c. Contractor must ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees, or hours of operation comparable to Medicaid FFS, if the Provider serves only Medicaid Enrollees.

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 monitor Network Providers regularly to determine compliance, and report to MDHHS on:

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.

5. Contractor must meet, and require its Network Providers to meet, and maintain MDHHS standards for timely access to care and services including contractual standards in Appendix 15, taking into account the urgency of the need for services.

D. Out of Network Providers

1. Contractor must provide adequate and timely access to, and authorize and reimburse Out-of-Network providers and cover Medically Necessary services for Enrollees if such services could not reasonably be obtained by a Network Provider on a timely basis inside or outside the State of Michigan. The Contractor must cover such Out-of-Network services for as long as the Contractor's Provider Network is unable to provide adequate access to covered Medically Necessary services for the identified Enrollee(s).

2. If Contractor cannot reasonably provide access to non-emergent Covered Services by a Network Provider within access requirements of this Contract, Contractor must include in its service authorization decision, the provision of Covered Services Out-of-Network.

3. 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).

4. 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.

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. Contractor 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 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 travel standards in Appendix 14 based on the PCP location compared to the Enrollee's home with the following exceptions:
        i. The Enrollee is CSHCS-eligible and a PCP over the travel standards to the Enrollee's home is the most appropriate for the Enrollee.
        ii. Contractor has been approved by MDHHS for an exception to the travel time and distance requirements for that particular Provider type and Region according to criteria in Appendix 14 and is able to document that no other Network Provider is accessible within the travel standards 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. Contractor 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, Contractor must receive MDHHS approval.
    d. Contractor must implement Enrollee PCP assignment within five business days of receipt of the Enrollee's PCP selected request.
    e. Contractor must report Enrollee's PCP selection, changes or deletions to MDHHS on the 5284 files within 10 business days of change.
    f. Contractor must allow Enrollee to change PCP by:
        i. Telephone or,
        ii. Written notification
    g. Contractor may offer an online PCP selection option to Enrollees.
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. Contractor must assign CSHCS Enrollees to CSHCS-attested PCP practices that provide family-centered care.
2. Contractor 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, including but not limited to; the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies:
        i. the transition time frame
        ii. transition approach
        iii. legal changes that take place in privacy and consent at age 18

3. Contractor 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 demonstrate that its network includes sufficient family planning Providers to ensure timely access to Covered Services. Family planning providers are providers who provide reproductive health care services to beneficiaries including but not limited to; family planning centers and clinics, Obstetrician/Gynecologists, and PCPs.
2. 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.
3. Contractor may encourage family planning Providers to communicate with PCPs once any form of medical treatment is undertaken. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization.
4. 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.
5. 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.
6. Contractor must maintain accessibility and confidentiality for family planning services through promptness in scheduling appointments, particularly for minors.
7. 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.
4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period.

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. Contractor 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.
3. In order to promote early intervention of behavioral health services among the young Medicaid population as an integral component of the delivery system, Contractor must support the MDHHS CAHCP behavioral health services initiative.
    a. Contractor recognizes the need for adequate network access for mild to moderate behavioral health services for the young Medicaid population.
    b. Contractor must contract with MDHHS designated CAHCP organizations who meet the minimum Medicaid Eligibility rate as determined by MDHHS, for increased access to mild-moderate behavior health services for youth 5-21 years of age.
    c. Contractor must comply with MDHHS guidance related to payer partner participation in the CAHCP initiative including, but not limited to:
        i. Sharing data and exchanging health information
        ii. Submission of CAHCP utilization reports as directed by MDHHS
        iii. Making payments according to the CAHCP Initiative payment to participating CAHCP organizations as determined and instructed by MDHHS

K. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC)

1. Contractor must provide Enrollees with access to services provided through FQHCs and RHCs if the Enrollee resides in the county in which an FQHC or RHC is located and if the Enrollee requests such services from such providers. Contractor must inform Enrollees of this right in their member handbooks.
2. Contractor must include, in its Provider Network, at least one FQHC and at least one RHC if available in each Region of its Service Area.
3. If a Contractor has an FQHC or RHC in its Provider Network in the county and allows Enrollees to receive Medically Necessary Services, including behavioral/mental health services, from the FQHC or RHC, the Contractor has fulfilled its responsibility to provide FQHC and RHC services in network..
4. Contractor must allow Enrollees to access Out-of-Network FQHCs or RHCs without prior authorization requirement for an Out-of-Network facility.

5. FQHC and RHC services may 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, or an RHC as applicable, in the Provider Network for the Region
6. The Social Security Act requires Contractors pay the FQHCs and RHCs at least as much as the Contractor pays to a non-FQHC or non-RHC provider for the same service. Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs and RHCs.
7. FQHCs and RHCs 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 or RHC subcontracts, as applicable with the 1903(m) organization.

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

1. Contractor must:
   a. Demonstrate that there are sufficient I/T/Us participating in the Provider Network to ensure timely access to services available under the Contract from such Providers for Native American Enrollees who are eligible to receive services.
   b. Pay I/T/Us, whether in the Provider Network or not, for Covered Services provided to Native American Enrollees who are eligible to receive services from such Providers as follows:
      i. At a rate negotiated between the Contractor and the I/T/U, or
      ii. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would pay for the services to a participating provider which is not an I/T/U; and
      iii. Make payment to all I/T/Us in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.
   c. Permit Native American Enrollees to obtain Covered Services from Out-of-Network provider from whom the Enrollee is otherwise eligible to receive such services.
   d. Permit an Out-of-Network I/T/U to refer a Native American Enrollee to a Network Provider.
2. If timely access to Covered Services cannot be ensured due to few or no I/T/Us, Contractor will be considered to have met the requirement in paragraph (1)(a) of this section if Indian Enrollees are permitted by Contractor to access out-of-State I/T/Us
3. If an Indian Health Facility or I/T/U provider is contracted with the Contractor, Native Americans who are Enrollees must be allowed to choose the I/T/U provider as their PCP as long as the provider has capacity to provide the services. If the I/T/U is not contracted with the Contractor, Native Americans must still be allowed to use the provider without authorization.
4. 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.).

M. 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 (XVI.-B).
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 will cover any special facility fees charged by CMDS clinics.

N. 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 (XVI-B).
3. Contractor must ensure services appropriate for youth transition into adulthood, including the adoption of a comprehensive transition policy and readiness assessment of need for a care manager and family-centered plan. If the need for family centered plan is determined, the plan must be updated annually.
4. Contractor may share Enrollee information with Local Health Departments to facilitate coordination of care without specific agreements.

O. 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.

P. Transition of Care

Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and the MDHHS transition of care policy to ensure continuity of care for its enrollees.

1. The Contractor's transition of care policy must ensure continued access to services during a transition from FFS to a managed care entity, or transition from one managed care entity to another when an Enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalism.
2. The transition of care policy must include at a minimum:
    a. Transitioning Enrollees have access to services consistent with the access they previously had.
    b. Transitioning Enrollees must be permitted to retain their current provider for the time period required in MDHHS' transition of care policy, if that provider is not in the Contractor's network.
    c. Transitioning Enrollees are referred to appropriate providers within the Contractor's network.
    d. The Contractor, if previously serving a beneficiary must fully and timely comply with requests for historical utilization, data from the beneficiary's new contractor or MDHHS.
3. The Contractor must include instructions to enrollees and potential enrollees on how to access continued services upon transition.

Q. Care Coordination

Contractor must ensure that the Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designates as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity.

1. Contractor must implement procedures to deliver care to and coordinate services for all Medicaid Health Plans (MHP), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP) Enrollees. These procedures must meet state requirements and Contractor must coordinated services the Contractor furnishes to the Enrollee
    a. Between settings of care, including appropriate discharge planning for short-term and long term hospital and institutional stays.
    b. With the services the Enrollee receives from any other MHP, PIHP or PAHP.
    c. With the services the enrollee receives in FFS Medicaid
    d. With the services the enrollee receives from community and social support providers
2. Contractor must make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment of all new Enrollees. Contractor must make subsequent attempts to conduct an initial

screening of each Enrollee's needs if the initial attempt to contact the Enrollee is unsuccessful.

3. Contractor must share with the state or other MHPs, PIHPs and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.
4. Contractor must ensure that each provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards.
5. Contractor must use and disclose individually identifiable health information, such as medical or dental records and any other health or enrollment information that identifies a particular Enrollee, in accordance with confidentiality requirements in 45 CFR parts 160 and 164.

VI. Covered Services

A. General

1. Contractor must have available and provide, at a minimum, the appropriate Medically Necessary Covered Services. Contractor's standards for determining Medically Necessary Services must not be more restrictive than standards used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes, regulations, the State Plan, Medicaid Provider Manual and other State policy and procedures. The Contractor
    a. Must provide all Early Periodic Screening Diagnostic and Treatment Services as required in this Contract.
    b. Must provide for the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.
    c. Must provide for the ability for an Enrollee to achieve age-appropriate growth and development.
    d. Must provide for the ability for an Enrollee to attain, maintain or regain functional capacity.
2. Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. 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.
4. Contractor may place appropriate limits on a service: (i) On the basis of criteria applied under the State plan, such as Medical Necessity; or (ii) For the purpose of utilization control, provided that:
    a. Services furnished can reasonably achieve their purpose, as required in this subsection;
    b. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and
    c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with this Contract.

5. 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.

6. 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. Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to the Subcontractor and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. If deficiencies or areas for improvement are identified, the Contractor and the Subcontractor will take corrective action.

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. Outpatient mental health services consistent with Appendix 7,

   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

   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

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

ll. Long-term care acute hospital services (LTACH)

mm. Dental services for pregnant beneficiaries

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 for all HMP beneficiaries

c. Hearing aids

3. Preventive Healthcare Services

a. Enrollees will have no cost share liability for preventive care services assigned a Grade A or Grade B by the United States Preventive Services Task Force (USPSTF) and all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration for individuals 21 years of age and older.

C. Health Promotion and Education

1. Contractor must not charge an Enrollee a fee for participating in health promotion and education programs for Covered Services as delineated in section VI-B (1)(a-ll) 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. Contractor must provide pharmacy services to Enrollees according to Medicaid Policy and MDHHS-established protocol and in accordance with 42 CFR 438.3(s), Contractor must:

    a. Provide coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act that meets the standards for such coverage imposed by section 1927 of the Act as if such standards applied directly to the Contractor.

    b. Report drug utilization data necessary for MDHHS to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than 45 Days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by NDC of each covered outpatient drug dispensed or covered by the Contractor.

    c. Provide a detailed description of its DUR program activities to MDHHS on an annual basis.

    d. Conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act, as if such requirements applied to the Contractor instead of the State.

2. Contractor 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. The DUR program must comply with the requirements described in section 1927(g) of the Act, 42 CFR part 456, subpart K, as if such requirement applied to the Contractor instead of the State and Section 1004 of the Support for Patients and Communities Act. Contractor's DUR program must include but not be limited to:

    a. Prospective safety edits for subsequent fills for drug categories that have high potential for abuse including opioids, and a claims review automated process that indicates when an enrollee is prescribed subsequent fill of potentially abusive drugs in excess of any limitation identified in State policy, guidance and/or pharmacy common formulary.

    b. Prospective safety edits on maximum Morphine Milligram Equivalents (MME) prescribed to enrollees for treatment of chronic pain and a claims review automated process that indicates when enrollees are prescribed the morphine equivalent for such treatment in excess of the maximum MME dose limitation identified in State policy, guidance and/or pharmacy common formulary.

    c. An automated process for claims review that monitors when enrollees are concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

    d. Include permitted exclusions for Enrollees that are:

        i. In hospice or palliative care
        ii. Receiving treatment for cancer
        iii. Who are residents of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy

iv. The State elects to treat as exempted from such requirements per policy

e. Monitor Antipsychotic Medication prescribed to Enrollees under the age of 18 and Enrollees in foster care.

i. Contractor must include in its DUR report, details of its Antipsychotic Medication monitoring activities for these Enrollees.

f. Monitor for potential fraud and abuse of controlled substances by Enrollees, healthcare providers and pharmacies including but not limited to participation in the Benefits Monitoring Program and the Michigan Automated Prescription System.

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 adhere to 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. Contractor must provide MDHHS 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 utilize the standard NCPDP reject 831-Product Service ID Carve Out, Bill Medicaid Fee for Service which instructs pharmacies to submit claims for FFS pharmacy carve-outs to the MDHHS vendor.

d. Contractor must provide MDHHS with information regarding the MCO Common Formulary pursuant to Section 1806 of Public Act 207 of 2018.

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. The process must include notification to the requesting pharmacy for MAC pricing reconsideration within 10 business days. Notification to the pharmacy must include identification of three National Drug

Codes (NDC) if there are 3 or more available, and all available NDCs, if there are fewer than 3, for the drug in question.

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.
14. Contractor must submit pharmacy claims data in accordance with MDHHS Pharmacy 340B policy and claim submission requirements.
15. Contractor's pharmacy Encounter Data must include data elements as required by MDHHS Pharmacy 340B policy and claim submission requirements.
16. Upon MDHHS request, Contractor must promptly collect and share submitted Network Provider claim data and drug purchase details for resolution of drug manufacturer 340B rebate disputes.
17. Contractor must have a unique set of pharmacy billing identifiers for their Medicaid line of business identified on their payer sheets (i.e., a unique combination of National Council of Prescription Drug Program's (NCPDP) Processor ID (previously known as Bank Identification Number (BIN))/American National Standards Institute (ANSI) Issue Identifier Number (IIN) and Processor Control Number (PCN)). The BIN/IIN and PCN are listed on the PBM/processor/plan's Payer Sheets for trading partners to know the proper identifiers for routing transactions.
18. The Contractor's reimbursement methodology for the Contractor's Pharmacy Benefits Manager (PBM) must be based on the actual amount paid by the PBM to a pharmacy for professional dispensing and ingredient costs. Contractor must prohibit contracted PBMs from engaging in the practice known as "spread pricing," where, in addition to any agreed-upon maintenance fee between the Contractor and the PBM, the PBM charges the Contractor more than the PBM pays the pharmacy for filling a prescription, and the PBM retains the difference
19. Effective January 1, 2020: High Cost Pharmacy Reimbursement: MDHHS will maintain a list of high cost drugs that will be reimbursable to the Contractor.
    a. MDHHS will reimburse Contractor for Drugs that are included on the MDHHS High Cost Pharmacy Reimbursement list.
    b. The Wholesale Acquisition Cost (WAC) will be used to identify drugs that meet the MDHHS designated cost per claim for the MDHHS High Cost Pharmacy Reimbursement List.
    c. MDHHS will reimburse the Contractor at least quarterly
    d. The High Cost Pharmacy Reimbursement List will be published on the MDHHS website at https://michigan.magellanrx.com.
    e. MDHHS will update the High Cost Pharmacy Reimbursement List when a new drug meets the cost threshold and its manufacturer has a signed rebate agreement with CMS. MDHHS will review and update the list at least annually.

20. Pharmacy Benefit Manager Agreements: If the Contractor enters into a contract or agreement (hereinafter referred to as "PBM agreement") with a PBM for the provision and administration of pharmacy services, the agreement must be developed as a pass-through pricing model as defined below. For the purposes of this Agreement, all requirements applicable to a PBM must also apply to any contract or agreement the Contractor has with a Pharmacy Benefit Administrator (PBA).

    a. For the purposes of this Agreement, a pass-through pricing model is defined as a PBM agreement type where:

        i. All monies related to services provided for the Contractor are passed through to the Contractor, including but not limited to: dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, Rebates, Inflationary Payments, and supplemental rebates;
        ii. All payment streams, including any financial benefits such as Rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the Contractor are fully disclosed to the Contractor, and provided to MDHHS upon request; and
        iii. The PBM is paid an administrative fee which covers their cost of providing the PBM services as described in the PBM contract as well as margin.

    b. The payment model for the PBM's administrative fee must be made available to MDHHS. If concerns are identified, MDHHS reserves the right to request any changes be made to the payment model.

    c. The PBM agreement must allow for the Contractor to perform a competitive market check every three years or allow the Contractor to annually renegotiate its terms.

    d. The following provisions must be included in any agreement between the Contractor and their PBM:

        i. At least annually, the PBM must hire an independent third party to complete a Service Organization Controls report (SOC-1) audit over the PBM's services and activities. This report must be provided to the Contractor, and information from this audit must be made available to MDHHS upon request.
        ii. The PBM must not steer or require any providers or members to use a specific pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between Contractors and PBMs to promote value-based reimbursement and purchasing or enhancing health outcomes are permitted.
        iii. The PBM must load member and provider eligibility information into their system within 24 hours of receipt of the eligibility file from the Contractor.
        iv. The PBM must report semi-annually to the Contractor their list of specialty drugs by NDC, including a report on any drugs that have moved between specialty and non-specialty designation.
        v. The PBM must submit a report containing data from the prior calendar year to the Contractor. The report must be made available to MDHHS upon request and contain the following information:

(v)i The aggregate amount of all rebates that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor; and

(v)ii The aggregate administrative fees that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor.

e. The following provisions must be addressed in any agreement between the Contractor and their PBM:

i. The ability for the Contractor, or its designee that has no ownership or control interest with the PBM, to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, remittance advices and other records to ensure the PBM's compliance with the terms and conditions of their agreement.

ii. If there is not a provision in the agreement to restrict the PBM from selling pharmacy data, the Contractor must require a secure process to be included and followed. If any Michigan Medicaid Contractor pharmacy data is sold, aggregate total amount received by the PBM for the Contractor's data must be reported to the Contractor at least semi-annually.

iii. The ability for the Contractor, at its discretion, to enter into non-exclusive specialty pharmacy network arrangements when a specialty pharmacy can provide a better price on a drug.

iv. A clause that allows the Contractor to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as unfair or deceptive business practices.

f. Disclosure of Financial Terms**:** Upon request, the Contractor must disclose to MDHHS all financial terms and arrangements for payment of any kind that apply between the Contractor and PBM or PBA. This disclosure must include financial terms and payment arrangements for formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and all other fees. MDHHS acknowledges that such information may be considered confidential and proprietary and thus must be held strictly confidential by MDHHS as specified in the Standard Contract Terms, Section 23 – Non-Disclosure of Confidential Information of this Contract.

g. Audit of PBM Agreements: MDHHS or its designee reserves the right to review and audit the PBM or PBA agreements between the Contractor and a PBM or PBA to ensure the PBM or PBA is fulfilling its contractual obligations limited to the Michigan Medicaid Program. The Contractor must be responsible for ensuring that any findings from these audits are corrected within the timeframe specified by MDHHS.

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. Contractor must provide EPSDT services as Medically Necessary in accordance with 42 USC Sec. 1396D(R)(5), 1396D(A)), 42 CFR part 441, Subpart B, and MSA 16-01 whether or not such services are covered under the State Plan and without regard to established limits.

2. Contractor must have a process that provides services to Enrollees for services not covered under the State Plan that have been determined to be Medically Necessary.

3. Contractor 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).

4. Contractor must make appropriate referrals for diagnostic or treatment services determined necessary by the Enrollee’s health care Provider.

5. Contractor must provide the appropriate services to correct or ameliorate any conditions found during the screening process.

6. 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 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 MDHHS network adequacy travel standards in Appendix 14. The time and distance must be calculated 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 including, but not limited to, Beneficiary Complaint resolution, mileage reimbursement and vehicle inspections.

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. Contractor must have ability to schedule and provide Enrollee transportation services for:

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

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

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. Contractor 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.

a. Contractor must submit an annual NEMT evaluation report. The report must include any findings of NEMT Subcontractor non-compliance and any corrective action plan and/or measures taken by the contractor to bring the Subcontractor into compliance.

b. 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 (STI), 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 12month 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.

c. The maximum stay is accumulated per assigned Contractor. If the Enrollee used Restorative/Rehabilitative health services while assigned to a different Contractor, those days are not counted.

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. Mental Health Outpatient Benefit

1. Contractor must provide outpatient mental health consistent with Appendix 7 and 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

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 referral 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 refer 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 refer 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 referral 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). Contractor must offer training and educational materials to Providers to facilitate this process.

4. Contractor 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) Contractor 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, Contractor 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. Contractor 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 and non-HMP pregnant beneficiaries.
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. Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
7. 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
8. 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
9. Custodial care in a nursing facility
10. Home and Community-Based Waiver Program services
11. Personal care or home help services
12. Transportation for services provided to persons with developmental disabilities which are billed through CMHSP
13. Coordination of care initiatives identified by MDHHS

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 10 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 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 Workers (CHW) in accordance with CHW requirements of this Contract 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.

b. Contractor agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by CHWs or Peer Support Specialists to promote behavioral health integration.

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. Contractor 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. Contractor must maintain an electronic bidirectional exchange of information with each Coordinating PIHP (XVI-B).

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 stratify Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.

c. Contractor must work with PIHPs to provide 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 provide 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 utilize the care management tool available in CC360 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 CHWs, 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 National Committee for Quality Assurance (NCQA) or Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP), Utilization Review Accreditation Commission (URAC), Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home, The Joint Commission (TJC) Primary Care Medical Home, Commission on Accreditation of Rehabilitation Facilities-Health Home (CARF), or under other PCMH standards approved by MDHHS.

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 maintain 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 medical and dental 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, cardiovascular disease and oral health disease.

v. Enrollees in need of Complex Care Management, including high risk Enrollees with dual behavioral health, and medical and oral 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 physical and oral 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 physical and oral 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 physical and oral 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

xiv. Assist Enrollees in meeting HMP work requirements as outlined in Appendix 5d of this contract.

c. Contractor must maintain and provide or arrange for the provision of a CHW to Enrollee ratio of at least one full-time CHW per 5,000 Enrollees.

d. Contractor must meet the CHW ratio requirement as follows:

i. One full-time CHW per 10,000 Enrollees not later than January 1, 2020

ii. One full-time CHW per 7,500 Enrollees not later than July 1, 2020

iii. One full-time CHW per 5,000 Enrollees not later than September 1, 2020

e. MDHHS will give Contractor 1.25 FTE credit toward meeting the contractually required ratio for every 1 FTE contractor purchases by contracting with a clinic or community-based organization for CHW services for their members.

f. Contractor must report the total CHW FTEs hired by contractor, contracted for through a clinic, or contracted for with a community-based organization to MDHHS annually as determined by MDHHS for MDHHS to calculate compliance with the contractually required ratio. MDHHS will utilize the 1.25 FTE credit toward meeting the ratio as applicable.

g. Contractor must provide that Enrollees have access to at least one CHW in each of its contracted Prosperity Region service areas.

h. Contractor must ensure CHWs are trained in all privacy laws and HIPAA provisions, and have successfully completed training in the following core competencies in order to serve Enrollees in the community.

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

viii. Behavioral health and substance use disorder

i. Contractor must submit their CHW curriculum to MDHHS for review upon request.

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 physical and oral 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 physical and oral 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 physical and oral health education services to ensure the entire spectrum of psycho-Social 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. 208 of 2018, 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. To establish the health status of Enrollees, a Health Risk Assessment (HRA) must be conducted using the MDHHS developed and approved HRA tool. The HRA:

      i. Will be completed and conducted by the Enrollee's PCP. Contractor must:

         (i) ii facilitate the timely receipt of an Enrollees' Initial Appointment with their PCP

         (i) iii establish a mechanism for obtaining the completed HRA, including PCP attestation, from the PCP. The PCP may submit a completed HRA via CHAMPS or the State's designated HRA fax line.

      ii. Completion will be initiated by the State Enrollment Services vendor upon initial enrollment with the Contractor via the telephone. HRA results will be transmitted via a secure gateway to the Contractor.

      iii. Will be completed and conducted by the Contractor for its Enrollees at any time during their enrollment with the Contractor. The HRA must:

         (iii)i Be conducted by appropriately credentialed personnel as directed and approved by MDHHS.

         (iii)ii Submitted in CHAMPS.

   c. Contractor 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 including but not limited to; HRAs, preventive health services and wellness programs in accordance with this Contract and MDHHS policy.

   e. Contractor 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.

   f. Contractor must store the results of the HRA and the healthy behavior goals set by the Enrollee. Contractor must store the results of the HRA and the healthy behavior goals set by the Enrollee. Contractor is required to use this HRA data to identify members who have identified healthy behaviors goal(s), and for outreach and education to these members. Contractor must also provide structured ongoing support to assist members with reaching their identified healthy behaviors(s) goal(s) in accordance with MDHHS policy.

g. Contractor must fully cooperate with all MDHHS monitoring of the healthy behavior incentives and assessment programs, in accordance with MDHHS policy.

h. Contractor must monitor the annual progress of Enrollees on their healthy behavior.

i. Contractor must encourage Enrollees to Engage in healthy behaviors in order to improve Enrollee health outcomes, self-reliance and productivity.

j. Contractor must submit healthy behavior records for all HMP enrollees who complete HRAs and wellness programs as directed and approved by MDHHS.

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, 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. Contractor 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, Contractor 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, Contractor 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. Contractor 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 (PSHCN)

Contractor is required to do the following for members identified by MDHHS as Persons with Special Health Care Needs (PSHCN):

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 CHIRs are functioning within the Contractor's service area, the Contractor must collaborate with CHIRs 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 438.330.
2. Contractor's QAPI must include: a) Performance improvement projects, b) collection and submission of performance measurement data, c) mechanisms to detect both underutilization and overutilization of services, and d) mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
3. Contractor's Medical Director must be responsible for managing the QAPI program.
4. 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.
5. 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 physical and oral 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, physical and oral health outcomes for Enrollees.
    e. Be made available to MDHHS annually through the compliance review or on request
6. 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
7. 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 and dental 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 physical and oral 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 physical and oral 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.
4. An annual assessment and documentation of the Contractor's 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.
5. 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. Annual Performance Improvement Projects

1. Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas including any performance improvement projects required by CMS.
2. Each performance improvement project must be designed to achieve significant improvement, sustained over time, in physical and oral health outcomes and Enrollee satisfaction, and must include the following elements:
    a. Measurement of performance using objective quality indicators.
    b. Implementation of interventions to achieve improvement in the access to and quality of care.
    c. Evaluation of the effectiveness of interventions based on performance measures.
    d. Planning and initiation of activities for increasing or sustaining improvement.
3. 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.
4. MDHHS will 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.
5. Contractor must assess performance for the priority areas identified by the collaboration of MDHHS and other stakeholders.

6. Contractor must report the status and results of each project conducted to MDHHS as requested, but not less than once per year as part of the compliance review.

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 template is attached to the Contract (Appendix 5).

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. Medical and Oral Health Coordination and Integration

1. Contractor recognizes the importance of coordinating and integrating oral and medical health Services to effectively address and improve Enrollee overall health status.
2. Contractor must work with MDHHS to develop initiatives to better coordinate and integrate services covered by the Contractor, dental vendors, and dental Providers serving Contractor's Enrollees.

3. Contractor must collaborate with, PCPs, community partners, dental Providers, dental vendors and MDHHS in the treatment and care of Enrollees.
4. Contractor must promote oral and medical health service collaboration among its Network Providers.
5. Contractor must engage in activities that work to increase awareness about the impact of oral health on Enrollee chronic disease outcomes and improve communication and Collaboration among dental Providers, community partners and medical professionals.
6. Contractor must engage in activities that will educate and build awareness of the benefits of integrated care to its medical Providers and dental Providers as applicable.
7. Contractor must build relationships with community partners that will engage in integrated care and promote good oral health practices.
8. Contractor must encourage its network PCPs to become trained to administer oral health screenings and fluoride varnish Services for patients between zero and three years of age.
9. Contractor reimburses network PCPs for Covered Services, including oral health screenings and fluoride varnish application for Enrollees zero to three years of age.

I. Utilization Management (UM)

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 Days from date of receipt for Standard Authorization Decisions and 72 hours from date of receipt for Expedited Authorization Decisions.
    b. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an Expedited Authorization Decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
    c. These timeframes may be extended up to 14 additional Days if:
        (i) The Enrollee, or the Provider, requests extension; or
        (ii) The Contractor justifies (to the State agency upon request) a need for additional information and 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.

J. 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. Contractor 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 must 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.

K. Contractor Compliance Reviews

1. Contractor compliance reviews will be conducted by MDHHS as an ongoing activity during the Contract period. 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.

2. MDHHS will determine if the Contractor meets contractual requirements and assess health plan compliance as outlined in this Contract. MDHHS reserves the right to conduct a comprehensive compliance review.

L. Contract Remedies, Sanctions and Penalties

1. MDHHS will 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, MDHHS may impose civil money penalties, late fees, performance penalties (collectively, "monetary sanction"), and other sanctions, on Contractor for Contractor's failure to comply with the terms of this Contract.

2. Monetary sanctions imposed pursuant to this contract may be collected by deducting the amount of the monetary sanction from any payments due to Contractor or by demanding immediate payment by Contractor. MDHHS, at its sole discretion, may establish an installment payment plan for payment of any monetary sanction. The determination of the amount of any monetary sanction shall be at the sole discretion of the MDHHS, within the ranges set by the MDHHS. Self-reporting by Contractor will be taken into consideration in determining the amount of any monetary sanction.

3. MDHHS will not impose any monetary sanction where the noncompliance is directly caused by the MDHHS's action or failure to act or where a force majeure delays performance by Contractor.

4. MDHHS may employ Contract remedies, penalties and/or sanctions to address any Contractor noncompliance with the Contract. Areas of noncompliance for which MDHHS may impose remedies, penalties 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 policy and operational process

j. Healthy Behavior policy and operational process

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

5. 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:

      i. 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.

      ii. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

      iii. 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).

      iv. 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.

   g. The State will give the Contractor timely written notice for any intermediate sanctions that specifies the basis and nature of the sanction.

6. 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.

a. The Contractor must be afforded a hearing before termination of a Contract under this Section can occur.

i. The State will give the Contractor written notice of its intent to terminate, the reason for the termination and the time and place of the hearing.

ii. After the hearing, the State will give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination

iii. For an affirming decision, give Enrollees of the Contractor notice of termination and allow Enrollees to disenroll, without cause and choose another Contractor.

7. 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.

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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 not 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 MI Health Account Fees

a. As established in P.A. 208 .of 2018, 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 fee 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 fee requirements.

c. Contractor must not request disenrollment for Enrollees' failure to remit required fees.

6. Contractor must give HMP Enrollees the option to pay their required cost-share via a credit/debit card option. Contractor must use the State contracted Enrollment Services vendor services for credit/debit card payment option to Enrollees.

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. Receive information on beneficiary and plan information

b. Be treated with respect and with due consideration for his or dignity and privacy

c. Receive Culturally and Linguistically Appropriate Services (CLAS)

d. Confidentiality

e. Participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about treatment options

f. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

g. Request and receive a copy of his or her medical records, and request those be amended or corrected

h. Be furnished health care services consistent with this Contract and State and federal regulations

i. Be free to exercise his or her rights without adversely affecting the way the Contractor, Providers, or the State treats the Enrollee

j. Be free from other discrimination prohibited by State and federal regulations

k. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand

B. Informational Materials for Enrollees

1. Contractor must provide all information required in 42 CFR 438.10 to Enrollees and Potential Enrollees in a manner and format that may be easily understood and is readily accessible by such Enrollees and Potential Enrollees as required in 42 CFR 438.10.

   a. Contractor must make its written materials that are critical to obtaining services, including at a minimum, provider directories, Enrollee handbooks, appeal and grievance notices and denial and termination notices available in the prevalent non-English languages in its Service Area.

   b. For consistency in the information provided to Enrollees and in accordance with 42 CFR 438.10, MDHHS will develop and require Contractor to use specific definitions for managed care terminology and model Enrollee handbooks and Enrollee notices.

2. 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 will 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.

   d. Formulary drug lists must be made available on the Contractor's Web site in a machine readable file. Contractor must make available in electronic or paper form, the following information about its formulary: (1) which medications are covered (both generic and name brand), and (2) the tier applicable to each medication.

   e. Contractor must publish the MCO Common Formulary or web link in a machine readable format on its website.

3. Contractor must address the need for culturally appropriate interventions for all Enrollee Services.

4. Contractor must make reasonable accommodations for Enrollees with hearing and/or vision impairments (e.g. signing video for deaf and hard of hearing).

5. 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.

6. Contractor must establish and maintain a toll-free 24 hours per day, seven Days per week telephone number to assist Enrollees.

7. Contractor must issue to all Enrollees an eligibility card that includes:

a. The toll-free 24 hours per day, seven Days per week phone number stated above

b. The Enrollee's Medicaid ID number

8. Contractor must submit at least weekly, a PCP Submission Update File (5284 file) that includes all PCP changes and additions made by the Contractor during that week.

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, including but not limited to transition services from pediatric to adult specialist providers.

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 delivered separately from the ID card

      i. Member materials stated above must be delivered to Enrollee 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. Contractor must provide the member handbook in a manner agreeable to the Enrollee either by mail or electronically. Member Handbooks will be considered provided to Enrollee if the Contractor:

      i. Mails a printed copy of the information to the Enrollee's mailing address.

ii. Provides the information by email after obtaining the Enrollee's written agreement to receive the information by email.

iii. Posts the information on the Contractor's website and advises the Enrollee in paper or electronic form that the information is available on the internet and includes the exact address to access the information. The Contractor must also provide that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

g. The Enrollee must be informed that the member handbook is available in paper form without charge upon request and the request must be processed within five Business Days. Contractor must submit to MDHHS, for approval, the process by which the Enrollee is informed of his/her choice of member handbook delivery prior to electronic delivery. Contractor must provide evidence that requests for the member handbook in paper form are processed within five Business Days.

h. If the Contractor utilizes electronic delivery method of member handbooks, Contractor must

i. Provide electronic delivery in accordance with 42 CFR 438.10.

ii. Have its alternative Enrollee mailing request process approved by MDHHS 30 Days prior to implementation.

i. At a minimum, the member handbook must include the following information as specified in 42 CFR 438.10(g)(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.

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 Covered Services necessary to provide routine and preventive health care services without a referral

ix. Enrollees' right to receive FQHC and RHC 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. Grievance, Appeal and fair hearing procedures and timeframes including: (1) The right to file Grievances and Appeals and Expedited Appeals, (2) The requirements and timeframes for filing, (3) The availability of assistance in the filing process (4) The right to request a State Fair Hearing after the Contractor has made a determination on an Enrollee's appeal which is adverse to the Enrollee, and (5) That fact that, when requested by the Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing.

xv. How Enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior

xvi. How to access hospice services

xvii. How to choose and change PCPs

xviii. How to contact the Contractor's Member Services and a description of its function

xix. How to access out-of-county and out-of-state services

xx. How to make, change, and cancel appointments with a PCP

xxi. How to obtain emergency transportation

xxii. How to obtain non-emergent transportation covered under this Contract

xxiii. How to obtain medically-necessary durable medical equipment (or customized durable medical equipment)

xxiv. How to obtain oral interpretation services for all languages, not just Prevalent Languages as defined by the Contract

xxv. How to obtain written information in Prevalent Languages, as defined by the Contract

xxvi. How to obtain written materials in Alternative Formats for Enrollees with special needs

xxvii. How to access community-based supports and services in Enrollees' service area

xxviii. Contractor's toll-free numbers for member services, medical management and the toll-free number Enrollees use to file a Grievance or Appeal and for any other unit providing services directly to Enrollees.

xxix. Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant

xxx. Procedures for obtaining benefits, including any requirements for service authorizations and/or specialty care and for other benefits not furnished by the Enrollee's primary care provider.

xxxi. Signs of substance use problems, available substance use disorder services and accessing substance use disorder services

xxxii. Vision services, family planning services, and how to access these services

xxxiii. Well-child care, immunizations, and follow-up services for Enrollees under age 21 (EPSDT)

xxxiv. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. The extent to which, and how, after hours and emergency coverage is provided, including: (1) what constitutes an emergency medical condition and emergency services, (2) the fact that prior authorization is not required for emergency services and (3) The fact that the Enrollee has a right to use any hospital or other setting for emergency care. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations

xxxv. What to do when family size changes

xxxvi. WIC Supplemental Food and Nutrition Program

xxxvii. Any other information deemed essential by the Contractor and/or MDHHS

xxxviii. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.

xxxix. Restrictions, if any, on the Enrollee's freedom of choice among network providers.

xl. The extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from Out-of-Network Providers. This includes an explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider.

xli. Information on how to report suspected Fraud or Abuse

xlii. How to access continued services upon transition to health plan.

j. Contractor must give Enrollee notice 30 Days prior to intended effective date of any significant changes outlined in Section Member Handbook, 2.i.

i. Significant is defined as any change that affects an Enrollee' Medicaid benefits including, but not limited to:

- Contractor contact information
- Authorization for services
- Covered benefits

- Co-pays

3. Medicaid Certificate of Coverage
    a. Contractor must provide Enrollees with a Certificate of Coverage.
    b. Contractor must provide MDHHS all new or amended DIFS approved Medicaid Certificates of Coverage.

F. Provider Directory

1. Contractor must maintain a complete Provider directory, reviewed for accuracy at least monthly, including written and web-based directories. Contractor must update Information included in a paper Provider directory at least monthly and electronic Provider directories must be updated no later than 30 Days after the Contractor receives updated Provider information.
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. Provider directories must be made available on the Contractor's Web site in a machine readable file.
    a. The Provider electronic directory must be made easily accessible to Enrollees. This means the Provider directory must have a clearly identifiable link or tab and may not require an Enrollee account or policy number to access the directory.
    b. Provider directory must accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.
    c. Contractor must include, in both electronic and print directories, a customer service email address, telephone number and/or electronic link that individuals may use to notify the Contractor of inaccurate Provider directory information.
3. Contractor's Provider directory must contain, at a minimum, the information listed in Appendix 16 for Network Providers.
    a. If applicable, the Provider directory must include note of prior authorization or referral requirement for certain Providers.
    b. Contractor must periodically audit at least a sample size of its Provider directory for accuracy and retain documentation of such audit to be made available to MDHHS upon request. Directory information for all PCPs, OB/GYNs, hospitals and outpatient behavioral health Providers must be audited at least annually.
4. Contractor 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; An Enrollee, or a third party acting on behalf of an Enrollee, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal. Unless an Enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

c. Contractor must seek MDHHS' approval of Contractor's Grievance and Appeal policies prior to implementation. These written policies and procedures must meet the following requirements:

i. Except as specifically exempted in this Section, the Contractor must administer an internal Grievance and Appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F).

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

iii. Contractor must have only one level of Appeal for Enrollees. An Enrollee may file a Grievance and request an Appeal with the Contractor.

iv. Contractor must make a determination on non-expedited Appeals not later than 30 Days after an Appeal is submitted in writing by the Enrollee. The 30 Day period may be tolled; however, for any period of time the Enrollee is permitted to take under the Medicaid Appeals procedure and for a period of time that must not exceed 14 Days if (1) the Enrollee requests the extension or (2) The Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest. The Contractor may not toll (suspend) the time frame for Appeal decisions other than as described in this Section.

v. Contractor must make a determination on Grievances within 90 Days of the submission of a Grievance.

vi. If Contractor extends the timeframes not at the request of the Enrollee, it must:

vi.i Make reasonable efforts to give the Enrollee prompt oral notice of the delay.

vi.ii Within two Days provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file an Appeal if he or she disagrees with that decision.

vi.iii Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

vii. If an Appeal is submitted by a third party,but does not include a signed document authorizing the third party to act as an authorized representative for the Beneficiary, the 30 Day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the Beneficiary that an authorized representative form or document is required. For purposes of this Section, "third party" includes, but is not limited to, health care Providers.

2. Grievance and Appeal Procedure Requirements

Contractor's internal Grievance and Appeal procedure must include the following components:

a. Contractor must give Enrollees timely and adequate notice of an Adverse Benefit determination in writing consistent with the requirements in §438.02, 438.10, 438.404 and this Contract. The notice must explain the following: (1) The Adverse Benefit Determination the Contractor has made or intends to make. (2) The reasons for the Adverse Benefit Determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (3) The Enrollee's right to request an Appeal of the Adverse Benefit Determination, including information on exhausting the Contractor's one level of Appeal and the right to request a State Fair Hearing. (4) The procedures for exercising their Appeal rights, the circumstances under which an Appeal process can be expedited and how to request it. (5) The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and, if allowed under State policy, the circumstances under which the Enrollee may be required to pay the costs of these services.

b. Contractor must mail the Adverse Benefit Determination notice within the timeframes specified in 438.404(c).

c. Contractor must allow Enrollees 60 Days from the date of the Adverse Benefit notice in which to file an Appeal.

d. Contractor must provide Enrollees reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

e. Contractor must acknowledge receipt of each Grievance and Appeal

f. Contractor must 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, nor a subordinate of any such individual; 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. When reviewing Appeals for CSHCS Enrollees, the Contractor must utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate or limit pediatric subspecialist provider services.

    iii. Must take into account all comments, documents, records and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit determination.

g. Contractor must provide that oral inquires seeking to Appeal an Adverse Benefit determination are treated as Appeals to establish the earliest

possible filing date for the Appeal and must be confirmed in writing, unless the Enrollee or the Provider requests expedited resolution.

h. Contractor must provide the Enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Contractor must inform the Enrollee of the limited time available for this sufficiency in advance of the resolution timeframe for Appeals in the case of Expedited Appeal resolution.

i. Contractor must provide the Enrollee and his or her representative the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals.

j. Contractor must consider the Enrollee, his or her representative, or estate representative of a deceased Enrollee as parties to the Appeal.

k. Contractor must 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 must be included in the member handbook and must 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 must be included in the member handbook and must 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 after the Contractor's one level Appeal process has been exhausted.

5. Contractor Decisions Subject to Appeal

a. When the Contractor makes a decision subject to Appeal, as defined in this Contract, the Contractor must provide a written Adverse Benefit determination notice to the Enrollee and the requesting Provider, if applicable. The Contractor must mail the notice within the following timeframes:(1) For termination, suspension, or reduction of previously authorized Medicaid-Services, within the timeframes specified in 42 CFR §§ 431.211,431.213, and 431.214. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in§

438.210(d)(1). (4) If the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with§ 438.210(d)(1)(ii), it must—(i) Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.(5) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. (6) For expedited service authorization decisions, within the timeframes specified in § 438.210(d)(2). Contractor must continue the Enrollee's benefits if all of the following conditions apply:

i. The Enrollee files the request for an Appeal timely in accordance with 438.402(c)(1)(ii) and (c)(2)(ii)

ii. The Appeal involves the termination, suspension, or reduction of a previously authorized services

iii. The services were ordered by an authorized Provider

iv. The period covered by the original authorization has not expired; and the Enrollee timely files for continuation of benefits, meaning on or before the later of the following:

1) Within 10 Days of the Contractor's mailing the Adverse Benefit determination notice

2) The intended effective date of the Contractor's proposed Adverse Benefit determination notice.

b. If the Contractor continues or reinstates the Enrollee's benefits while the Appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

i. The Enrollee withdraws the Appeal or request for State Fair Hearing.

ii. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 Days after the Contractor mails an adverse resolution to the Enrollee's Appeal.

iii. A State Fair Hearing decision adverse to the Enrollee is made.

iv. The authorization expires or authorization service limits are met.

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

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

6. Adverse Benefit Determination Notice

a. Adverse Benefit determination notices involving Service Authorization Request decisions that deny or limit services must be made within the time

frames described in this Contract. Adverse Benefit Determination Notices pursuant to claim denials must be sent on the date of claim denial for termination, suspension, or reduction of previously authorized Medicaid-Covered Services Contractor must mail Adverse Benefit Determination Notices within the following timeframes:

i. At least 10 Days before the date of action, except as permitted under §§431.213 and 431.214.

ii. The Contractor may send an Adverse Benefit Determination Notice not later than the date of action if (less than 10 Day before as required above):

(1) The Contractor has factual information confirming the death of an Enrollee

(2) The Enrollee submits a signed written statement that:

a. He/she no longer requests the services or;

b. The Enrollee gives information that requires termination or reduction of services and indicates that he/she understands that service termination or reduction will result

(3) The Enrollee has been admitted into an institution where he/she is ineligible under the plan for further services.

(4) The Enrollee's whereabouts are unknown and the post office returns the Contractor's mail directed to the Enrollee indicating no forwarding address.

(5) The Contractor verified with MDHHS that the Enrollee has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

(6) A Change in the level of medical care is prescribed by the Enrollee's Provider.

(7) The notice involves an Adverse Benefit Determination with regard to preadmission requirements.

iii. The Contractor may shorten the period of advance notice to five Days before the date of action if:

(1) The Contractor has facts indicating that action should be taken because of probable Fraud by the Enrollee; and

(2) The facts have been verified, if possible, through secondary sources.

b. The notice must include the following components:

i. The Adverse Benefit Determination the Contractor has taken or intends to take.

ii. The reasons for the Adverse Benefit Determination, including the right of the Enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination. Such information included medical criteria, and any processes, strategies or evidentiary standards used in setting coverage limits.

iii. The Enrollee's right to request an Appeal, including information on exhausting the Contractor's one level of Appeal and the right to request a State Fair Hearing.

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, and how to request that benefits be continued.

viii. Must be mailed in a timely manner in accordance with 438.404(c).

c. 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.

    c. An Enrollee may request a State Fair Hearing only after receiving notice that the Contractor has upheld its Adverse Benefit Determination.

        i. If the Contractor fails to adhere to the required Appeals notice and timing requirements in 438.408, the Enrollee is deemed to have exhausted the Contractor's Appeals process.

    d. The Contractor must allow the Enrollee 120 Days from date of the Contractor's Appeal resolution notice to request a State Fair Hearing

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 Benefit Determination.

    c. Contractor must make a decision on the Expedited Appeal within 72 hours of receipt of the Expedited Appeal. .

    d. Contractor must give the Enrollee oral and written notice of the Appeal resolution.

    e. If the Contractor denies the request for an Expedited Appeal, the Contractor must transfer the Appeal to the standard Appeal resolution timeframe and give the Enrollee written notice of the denial within two 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.

9. Grievance and Appeals Records

    The Contractor and its subcontractors as applicable, must maintain record of all Grievance and Appeals

    a. The record of each Grievance and Appeal must contain, at a minimum all of the following:

        i. A general description of the reason for the Appeal or Grievance

        ii. The date received

        iii. The date of each review or, if applicable, review meeting

iv. Resolution at each level of the Appeal and/or Grievance

v. Date of resolution for each Appeal and/or Grievance

vi. Name of covered person for whom the Appeal or Grievance was filed

b. Grievance and appeals records must be accurately maintained in a manner accessible to the State and available upon request to CMS.

c. Grievance and appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

d. Contractor must identify CSHCS beneficiaries and CSHCS corresponding Medicaid identification numbers on its appeals and grievances records. Contractor must have the ability to report CSHCS grievance and appeals records upon request.

XIV. Provider Services

A. Provider Services

1. Contractor must provide contract and education services for the Provider Network, including education regarding Fraud, Waste 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. Contractor 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 and must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
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 and 42 CFR 438.214 regarding the credentialing and re-credentialing of Providers within the Contractor's Provider Network, including, but not limited to the requirements specified in this Section. Contractor must implement written policies and procedures for selection and retention of Network Providers that, meet uniform credentialing and recredentialing policies established by MDHHS including policies that address acute, primary, and outpatient behavioral Providers. Contractor must follow a documented process for credentialing and recredentialing of Network Providers.

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 42 CFR §447.45 and MCL 400.111i and in compliance with established MDHHS performance standards

a. Contractor must pay 90 percent of all Clean Claims from practitioners within 30 Days of the date of receipt.

b. Contractor must pay 99 percent of all Clean Claims from practitioners within 90 Days of the date of receipt

c. Clean Claim means all claims as defined in 42 CFR §447.45 and MCL 400.111i.

d. Contractor must ensure that the due date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

e. 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.

f. Contractor must make all payments to both network and Out-of-Network providers.

g. Contractor will not be responsible for any payments owed to Providers for services rendered prior to a Beneficiary's effective enrollment date with the Contractor.

h. 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.

i. Contractor must develop programs to facilitate outreach, education and prevention services with both network and Out-of-Network providers.

j. Contractor must provide an annual summary of the outreach, education, and prevention services annually to MDHHS as part Contractor compliance review activities. .

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. Provider Preventable Conditions
    a. Contractor is prohibited from making payment to a Provider for provider-preventable conditions that are outlined in the Michigan State Plan.
    b. Contractor must require all Providers to report provider-preventable conditions associated with claims for payment or Enrollee treatment for which payment would otherwise be made in accordance with federal Medicaid regulations.
4. 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.
5. 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.
6. 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.

7. 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.

8. 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.

9. Family Centered Medical Home

   Contractor 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. $6 to each Primary Care Provider serving an HMP CSHCS Enrollee
   c. $8 to each Primary Care Provider serving an ABAD CSHCS Enrollee

10. 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 42 CFR 438.242 and MDHHS. The system must provide information on areas including, but not limited to, utilization, claims, Grievances and Appeals, and disenrollments for other than loss of Medicaid eligibility. 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 (TPL) 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 will 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 120 Days of the end of each month.
    a. In the event that an issue or error with enrollment files becomes known, MDHHS will communicate the issue, status and working resolution with the Contractor.
    b. Should the issue or error affect the Contractor's ability to reconcile enrollment files, MDHHS will communicate appropriate workarounds, operational revisions or revise deliverable requirements as appropriate to the outstanding issue or error.
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. Contractor must ensure all Encounter Data is complete and accurate for the purposes of rate calculations and quality and Utilization Management.
2. Contractor must provide for collection and maintenance of sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees.
3. Contractor must ensure data received from Providers is accurate and complete by:
    a. Verifying the accuracy and timeliness of the data, including data from Network Providers the Contractor is compensating on the basis of Capitation Payments
    b. Screening the data for completeness, logic and consistency
    c. Collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts
    d. Identifying and tracking Fraud, Waste and Abuse
4. Contractor must make all collected data available to MDHHS and upon request to CMS, including submission of all Enrollee Encounter Data that MDHHS is required to report to CMS under § 438.818.

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. High Cost Pharmacy reimbursement request for pharmacy costs for which the Contractor was eligible for High Cost Pharmacy reimbursement but has not received after the quarterly payout.
5. 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 weekly.
2. Contractor must submit the addition, change or deletions within 10 business days of the PCP assignment or change.
3. Contractor must submit a complete 5284 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. 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.
5. Contractor must ensure capacity to, at a minimum, receive admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination response hospital admissions and readmissions at the plan level and within its provider network.
6. Contractor must ensure capabilities to collect, store, and incorporate clinical quality information into their provider quality measurement and improvement programs to enhance the health plan's capacity to measure and improve the clinical health outcomes of their members. The proportion of their total provider network and membership used to meet this requirement will be established by the Contractor.

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. Contractor is prohibited from making payment as applicably restricted in section 1903(i) of the Social Security Act.
4. 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 Fraud, Waste 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. Contractor 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 health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the approved Medicaid state plan. 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, including recoveries from any related court judgment or settlement if Contractor has been notified of the legal action. Contractor must follow the "Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing" as described in the Michigan State Medicaid Plan, Attachment 4.22-B, Page 1. Contractor may pursue cases below the thresholds at their discretion.

1. Contractor must seek to identify and recover all sources of third party funds based on industry standards and those outlined by MDHHS TPL Division.
2. Contractor may retain all such collections. If third party resources are available and liability has been established, the Contractor is required to follow Medicaid policy, guidance, and all applicable state and federal statutes, the Medicaid Provider Manual, the State Plan, and the TPL Guidelines and Best Practices Guidance for cost avoiding Medicaid covered services.
3. Contractor must follow Medicaid Policy, guidance and all applicable state and federal statutes regarding TPL. MDHHS TPL policy information can be found in federal regulations, Michigan Compiled Law, MDHHS, Medicaid Provider Manual, the State Plan, and TPL Guidelines, and are available upon request. Contractor use of best practices is strongly encouraged by MDHHS and are available in the TPL Guidelines and Best Practices Guidance. Contractor must develop and implement written policies describing its procedures for TPL recovery. MDHHS will review Contractor's policies and procedures for compliance with this contract and for consistency with TPL recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.
4. Contractor must submit a Risk Mitigation and Action Plan in a format required by MDHHS, to address any risk identified in the MDHHS Dashboard within 90 days of an MDHHS request.
5. Contractor must report third party collections through Encounter Data submission and in aggregate as required by MDHHS.
6. Throughout the Contract term, Contractor must comply in full with the provision of third party recovery data to MDHHS in the electronic format prescribed by MDHHS. Recovery data must be submitted on a quarterly basis. Activities performed October through December will be reported by February 15; activities performed January through March reported by May 15; activities performed April through June reported by August 15; and activities performed July through September reported by November 15.

7. 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.
8. MDHHS will provide the Contractor with all known third party resources for its Enrollees. This information is available real-time within CHAMPS or through 270 requests. MDHHS will provide the most recent data to Contractor on the daily 834 HIPAA compliant enrollment file. MDHHS will provide Contractor with a full history of known third party resources for Enrollees through a secure file transfer process.
9. 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.
10. 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.
11. Contractor must respond within 30 days of subrogation notification pursuant to MCL 400.106 (10).
12. Contractor must cooperate with TPL subrogation best practices including but not limited to;
    a. Provide MDHHS with most recent contact information of Contractor's assigned TPL staff including staff name(s), fax and telephone numbers. Contractor must inform MDHHS in writing within 14 Days of vacancy or staffing change of assigned TPL staff.
    b. Record and report TPL quarterly subrogation activities to MDHHS on a template developed by MDHHS.
13. Contractor is prohibited from recovering loss directly from the beneficiary.

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 and requirements established by MDHHS, State, and 42 CFR § 438.104.
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 and Health Fairs 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

Contractor may participate in health fairs that meet the following guidelines:

1. 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.
2. 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.
3. Beneficiary attendance is voluntary; no inducements other than incentives approved by MDHHS under this Contract may be used to encourage or require participation.
4. 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.
5. 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.
6. 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.
7. 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 dated
    b. All medical records must be retained for at least 10 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

M. Medical Loss Ratio

1. Contractor must meet Medical Loss Ratio requirements as outlined in 42 CFR 438.8, this contract and other applicable federal and state statutes, policies and/or guidance. Failure of Contractor to meet the Medical Loss Ratio requirement will result in the State exercising contract remedies including but not limited to financial sanctions.

N. Dental Claim Cost Loss Ratio

1. Contractor must meet the Dental Claim Cost Loss Ratio utilization target as outlined in this contract. The established MDHHS Dental Claim Cost Loss Ratio is a comparison of dental costs incurred by the Contractor in relation to the dental benefit expense included in HMP capitation rate paid to the Contractor that includes a minimum dental utilization assumption. MDHHS developed the Dental Claim Cost Loss Ratio using the composite projected annual utilization per 1000 enrollees in the HMP Dental Utilization capitation rates outlined in the State of Michigan Medicaid Rate Certification Letter to CMS. The composite represents the approximate average number of services anticipated in the year per member for the paid dental capitation rate.

2. Contractor must meet the minimum utilization target of 80% of the base utilization included in the paid dental HMP capitation rates. Failure to meet the minimum utilization target will result in a performance penalty in which MDHHS will recover 100% of the difference between the incurred dental benefit expense and the benefit expense component of the HMP dental capitation rate paid to the Contractor.

3. MDHHS will calculate the Dental Cost Loss Ratio for dental expenses using Contractor encounter data for dental services incurred for the period beginning October 1, 2019 through September 30, 2020 with a six month claims run-off allowance.

XVIII. Program Integrity

The MDHHS Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Michigan Medicaid Health Plans consistent with this Contract and the requirements under 42 CFR 438.608.

A. Fraud, Waste and Abuse **–** Contractor must implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste, and Abuse, including a mandatory compliance plan. The arrangements or procedures must include the following:

1. Contractor's Fraud, Waste and Abuse compliance program and plan must include, at a minimum, all of the following elements:

    a. Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable Fraud, Waste, and Abuse requirements and standards under the Contract and all applicable Federal and State requirements.

        i. Standards of Conduct –Contractor must have written standards of conduct that clearly state the Contractor's commitment to comply with all applicable statutory, regulatory and Medicaid program requirements. The standards of conduct must be written in an easy to read format and distributed to all employees. All employees must be required to certify that they have read, understand and agree to comply with the standards.

        ii. Written Compliance Policies and Procedures-Contractor must have comprehensive written compliance policies and procedures, developed under the direction of the compliance officer and Compliance Committee, which direct the operation of the compliance program.

            The written compliance policies and procedures must include, at a minimum, the following elements:

            (ii)i Duties and responsibilities of the compliance officer and Compliance Committee

            (ii)ii How and when employees will be trained

            (ii)iii Procedures for how employee reports of non-compliance will be handled

            (ii)iv Guidelines on how the compliance department will interact with the internal audit department

            (ii)v Guidelines on how the compliance department will interact with the legal department

            (ii)vi Guidelines on how the compliance department will interact with the Human Resources department

            (ii)vii Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance

            (ii)viii Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct

            (ii)ix Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures

    b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with Contract requirements and who reports directly to the Chief Executive Officer and the Board of Directors.

i. Contractor must designate a compliance officer whose primary responsibility is to oversee the implementation and maintenance of the compliance program.

ii. The compliance officer must have adequate authority and independence within the Contractor's organizational structure in order to make reports directly to the board of directors and/or to senior management concerning actual or potential cases of non-compliance.

iii. The compliance officer must also report directly to corporate governance on the effectiveness and other operational aspects of the compliance program.

iv. The compliance officer's responsibilities must encompass a broad range of duties including, but not limited to, the investigation of alleged misconduct, the development of policies and rules, training officers, directors and staff, maintaining the compliance reporting mechanism and closely coordinating with the internal audit function of the Contractor.

c. The establishment and continued maintenance of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with requirements under the Contract.

i. Contractor must establish a compliance committee of the Board of Directors and an Executive compliance committee that advises the compliance officer and assists in the implementation of the compliance program. An executive compliance committee below the Board level would be able to quickly identify and raise internal issues of which the Board committee may not be aware.

ii. The executive committee would provide guidance and information to the compliance officer but must not have the authority to block or interfere with any actions taken or proposed to be taken by the compliance officer.

iii. The executive compliance committee maybe comprised of the heads of the major departments within the Contractor, such as Provider Audit, Claims, Human Resources and the General Counsel, as well as any other departments that may be high risk areas.

iv. The compliance officer must chair the executive compliance committee.

v. The executive compliance committee must meet more frequently than the Board's committee.

d. A system for training and education for the compliance officer, the Contractor's senior management, and the Contractor's employees on Federal and State standards and requirements under the Contract. The Compliance Officer must not perform their own training and education.

i. Formal Training Programs – Contractor must provide general compliance training to all employees, officers, managers, supervisors, board members and long-term temporary employees that effectively communicates the

requirements of the compliance program, including the company's code of conduct and applicable Medicaid statutory, regulatory and contractual requirements.

(i)i Contractor must also determine under what circumstances it may be appropriate to train non-employee agents and contractors.

(i)ii Employees, officers, managers, supervisors and Board members must be required to attend compliance training sessions and to sign certifications that they have completed the appropriate sessions.

(i)iii The initial compliance training for new employees must occur within 90 days of the date of hire.

(i)iv Contractor must provide annual refresher compliance training that highlights compliance program changes or other new developments. The refresher training should re-emphasize Medicaid statutory, regulatory and contractual requirements and the Contractor's code of conduct.

ii. Informal On-going Compliance Training –Contractor must employ additional, less formal means for communicating its compliance message such as posters, newsletters and Intranet communications. The compliance officer must be responsible for the content of the compliance messages and materials distributed to employees and managers.

e. Effective lines of communication between the Compliance Officer and the Contractor's employees.

i. Hotline or Other System for Reporting Suspected Noncompliance- Contractor must have mechanisms in place for employees and others to report suspected or actual acts of non-compliance.

(i)i In order to encourage communications, confidentiality and non-retaliation policies must be developed and distributed to all employees.

(i)ii Contractor must use e-mails, newsletters, suggestion boxes, and other forms of information exchange to maintain open lines of communication.

(i)iii A separate mechanism, such as a toll-free hotline, must be employed to permit anonymous reporting of non-compliance.

(i)iv Matters reported through the hotline or other communication sources that suggest substantial violations of compliance policies or health care program statutes and regulations must be documented and investigated promptly to determine their veracity.

(i)v Contractor must create an environment in which employees feel free to report concerns or

incidents of wrongdoing without fear of retaliation or retribution, when making a good faith report of non-compliance.

ii. Routine Communication and Access to the Compliance Officer – Contractor must have a general "open door" policy for employee access to the compliance officer and the Compliance Department staff. Staff must be advised that the compliance officer's duties include answering routine questions regarding compliance or ethics issues.

iii. The Compliance Officer must establish, implement and maintain processes to inform the Contractor's employees of procedure changes, regulatory changes, and contractual changes.

f. Enforcement of standards through well-publicized disciplinary guidelines.

i. Consistent Enforcement of Disciplinary Policies – Contractor must maintain written policies that apply appropriate disciplinary sanctions on those officers, managers, supervisors, and employees who fail to comply with the applicable statutory and Medicaid program requirements, and with the Contractor's written standards of conduct. These policies must include not only sanctions for actual noncompliance, but also for failure to detect non-compliance when routine observation or due diligence should have provided adequate clues or put one on notice. In addition, sanctions should be imposed for failure to report actual or suspected non-compliance.

(i)i The policies must specify that certain violations, such as intentional misconduct or retaliating against an employee who reports a violation, carry more stringent disciplinary sanctions.

(i)ii In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.

(i)iii Contractor may identify a list of factors that will be considered before disciplinary action will be imposed. Such factors may include degree of intent, amount of financial harm to the company or the government or whether the wrongdoing was a single incident or lasted over a long period of time.

ii. Employment of, and Contracting with, Ineligible Persons –Contractor must have written policies and procedures requiring a reasonable and prudent background investigation to determine whether prospective employees and prospective non-employee subcontractors or agents were ever criminally convicted, suspended, debarred or excluded from participation in a federal program.

Contractor must also conduct periodic reviews of current employees and/or subcontractors and agents to determine whether any have been suspended or

debarred or are under criminal investigation or indictment. If an employee or non-employee agent or subcontractor is found to be ineligible, Contractor must have a written policy requiring the removal of the employee from direct responsibility for, or involvement with, the Medicaid program, or for the termination of the subcontract, as appropriate.

g. Establishment and implementation, and ongoing maintenance of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with requirements under the Contract.

i. Auditing – Contractor must have a comprehensive internal audit system to ensure that the Contractor is in compliance with the range of contractual and other MDHHS requirements in critical operations areas. The internal auditors must be independent from the Contractor's management team and competent to identify potential issues within the critical review areas. The auditors must have access to existing audit resources, relevant personnel and all relevant operational areas. Written reports must be provided to the compliance officer, the Compliance Committee and appropriate senior management. The reports must contain findings, recommendations and proposed corrective actions that are discussed with the compliance officer and senior management.

Contractor must ensure that regular, periodic evaluations of its compliance program occur to determine the program's overall effectiveness. This periodic evaluation of program effectiveness may be performed internally, either by the compliance officer or other internal source - or by an external organization. These periodic evaluations must be performed at least annually, or more frequently, as appropriate.

ii. Monitoring – Contractor must have a means of following up on recommendations and corrective action plans to ensure that they have been implemented. Contractor must develop an Exit Interview Questionnaire that includes questions regarding whether the exiting employee observed any violations of the compliance program, including the code of conduct, as well as any violations of applicable statutes, regulations and Medicaid program requirements during the employee's tenure with the Contractor. The Compliance Department must review any positive responses to questions regarding compliance violations.

2. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to MDHHS-OIG. See Section XVIII.B of this Contract for the method and timing of such reporting.

    a. Contractor must have the right to recover overpayments directly from Providers for the post payment evaluations initiated and performed by the Contractor.

        i. Pursuant to 42 CFR § 438.608(d)(1)(iv), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

    b. Pursuant to 42 CFR § 438.608(a)(7), the Contractor must promptly refer any potential Fraud, Waste, or Abuse that the Contractor identifies to MDHHS-OIG.

        i. If the Contractor identifies an overpayment involving potential Fraud, Contractor must promptly refer the case to MDHHS-OIG and obtain written consent from MDHHS-OIG prior to recovering the overpayment.

        ii. Contractor must notify MDHHS OIG when initiating a recovery regarding an overpayment involving potential Waste and/or Abuse in accordance with the procedures in Section XVIIIB of this contract.

    c. Contractor must have a mechanism for Providers to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 days of overpayment identification (in accordance with 42 CFR § 401.305 and MCL 400.111b(16)), and to notify the Contractor in writing for the reason for the overpayment.

    d. MDHHS-OIG will perform post payment evaluations of the Contractor's Network Providers for any potential Fraud, Waste and Abuse and to recover overpayments made by the Contractor to their Network Providers when the post payment evaluation was initiated and performed by MDHHS-OIG.

        i. Contractor's Network Providers must adhere to the Medicaid Provider Manual.

        ii. Contractor's Network Providers must agree that MDHHS-OIG has the authority to conduct post payment evaluations of their claims paid by the Contractor.

        iii. Contractor's Network Providers must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post payment evaluations conducted by MDHHS-OIG.

        iv. Section XVIII.A.2.d(i-iii) requirements must be included in the Contractor's:

            (iv)i Provider enrollment agreements that must be in effect by January 1, 2019 and/or;

            (iv)ii Provider manual – if the Provider enrollment agreements in effect by January 1, 2019 require Providers to adhere to the Contractor's provider manual.

v. Prior to initiating a post payment evaluation of a Contractor's Network Provider, MDHHS-OIG will:

(v)i Review the Contractor's quarterly submission information to determine whether the Contractor:

a. Performed a post payment evaluation of the Provider in the previous 12-month period or;

b. Is currently performing post payment evaluation of the Provider.

(v)ii Contact the Contractor to determine whether the Contractor has identified concerns with the Provider. The Contractor must respond to MDHHS-OIG within 10 Business Days of being contacted by MDHHS-OIG.

vi. If MDHHS-OIG proceeds with a post payment evaluation, MDHHS-OIG will:

(vi)i Limit the scope to dates of service that are at least one year old, and;

(vi)ii Notify the Contractor in writing and request applicable information from the Contractor. (Applicable information may include, but is not limited to; detailed Contractor post payment evaluation history with the Provider, Contractor communication history with the Provider, signed provider enrollment agreement for the Provider, relevant Contractor policy, etc.) Contractor must provide MDHHS-OIG with the name of an individual that will act as the main Contractor contact for each post payment evaluation. Contractor must provide the requested information within 10 Business Days of MDHHS-OIG request.

(vi)iii Determine if a claim-based audit or a sample/extrapolation post payment evaluation will be performed.

vii. If an overpayment is identified:

(vii)i MDHHS-OIG will provide written preliminary results to both the Provider and Contractor. The Provider will be permitted opportunity to submit additional information by the due date indicated on the preliminary results letter (normally 30 Days) to substantiate their claims.

(vii)ii MDHHS will review any additional information submitted by the Provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306) to both the Contractor and the Provider.

a. If the Provider does not appeal the final findings, MDHHS-OIG will proceed with recovering overpayments from the Contractor.

b. If the provider appeals the final findings, MDHHS-OIG will not initiate recoupment from the Contractor until the appeal is resolved.

c. If the provider appeals the final findings and the appeal is resolved in the State's favor, MDHHS-OIG will proceed with recovering the overpayment from the Contractor.

viii. Pursuant to 42 U.S.C. § 1396b, the State has one year from the date of discovering an overpayment before it must refund the federal portion of the overpayment to the federal government, regardless of recovery from the Provider. Overpayments identified by MDHHS-OIG will be recovered from the Contractor via an MDHHS withhold or offset from the next capitation payment or primary push pay to the Contractor.

(viii)i Contractor is responsible for the recovery of overpayments from their Providers.

ix. Contractor must make all necessary adjustments to encounter data resulting from MDHHS-OIG post payment evaluations and the Contractor must notify MDHHS-OIG when the adjustments are complete.

3. Provision for prompt notification to MDHHS when it receives information about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility, including but not limited to;

a. Changes in the Enrollee's residence;

b. The death of an Enrollee.

4. Provision for notification to MDHHS-OIG when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. See Section XVIII.B of this Contract for method and timing of such reporting.

5. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis.

a. Contractor must have methods for identification, investigation and referral of suspected Fraud cases (42 CFR § 455.13, 455.14, 455.21).

b. Contractor must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential Fraud, Waste and Abuse activities.

i. Special Investigations Unit – The Contractor must operate a distinct Fraud, Waste and Abuse Unit, Special Investigations Unit (SIU).

(i)i The investigators in the unit must detect and investigate Fraud, Waste and Abuse by its Michigan Medicaid Enrollees and Providers. It must be separate from the Contractor's utilization review and quality of care functions. The unit can either be a part of the Contractor's

corporate structure, or operate under contract with the Contractor.

(i)ii On a yearly basis, the Contractor's SIU or its designee, must conduct program integrity training to all applicable areas or function with the Contractor to enhance information sharing and referrals to the SIU regarding Fraud, Waste and Abuse within the Contractor's Medicaid program.

c. Contractor, at a minimum, must perform the following verification processes:

i. Explanation of Benefits (EOBs) – Contractor must generate and mail EOBs to Michigan Medicaid Enrollees in accordance with guidelines described by MDHHS. Contractor must provide at least monthly EOBs to a minimum of 5% of the Enrollees for whom services were paid (no rounding).

(i)i Contractor must omit any claims in the EOB file that are associated with sensitive services. The Contractor, with guidance from MDHHS, must develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

(i)ii At a minimum, EOBs must be designed to address requirements found in 42 CFR § 455.20 and 433.116.

(i)iii Contractor must ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types.

(i)iv The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS.

ii. Contractor must track any complaints received from Enrollees and resolve the complaints according to its established policies and procedures based on the EOBs sent to Michigan Medicaid Enrollees. The resolution may be Enrollee education, Provider education or referral to MDHHS-OIG. The Contractor must use the feedback received to modify or enhance the EOB sampling methodology.

iii. Contractor must report all EOB activities performed within the previous quarter to MDHHS-OIG. See Section XVIII.B of this Contract for the method and timing of such reporting.

d. Data Mining Activities – Contractor must have surveillance and utilization control programs and procedures (42 CFR § 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments.

Contractor must utilize statistical models, complex algorithms and pattern recognition programs to detect possible fraudulent or abusive practices. The Contractor must report all data mining activities performed (including all program integrity cases opened as a result) within the previous quarter to MDHHS-OIG. See Section XVIII.B of this Contract for the method and timing of such reporting.

e. Preliminary Investigations – Contractor must promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste and

Abuse. The Contractor must report all tips (any program integrity case opened within the previous quarter) to MDHHS-OIG. See Section XVIII.B. of this Contract for the method and timing of such reporting.
All confirmed or suspected provider Fraud must immediately be reported to MDHHS-OIG.

Unless prior written approval is obtained from MDHHS-OIG, Contractor must not take any of the following actions as they specifically relate to Michigan Medicaid claims:

i. Contact the subject of the investigation about any matters related to the investigation;
ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

f. Audit Requirements – Contractor must conduct risk-based auditing and monitoring activities of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste or Abuse. These audits should include a retrospective medical and coding review on the relevant claims.

In accordance with the Affordable Care Act, Contractor must promptly report overpayments made by Michigan Medicaid to the Contractor as well as overpayments made by the Contractor to a provider and/or Subcontractor. See Section XVIII.B of this Contract for the method and timing of such reporting.

g. Prepayment Review – If the Contractor subjects a provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to the Contractor considering it for payment, as a result of suspected Fraud, Waste and/or Abuse, the Contractor must obtain written consent from MDHHS-OIG prior to placing any providers on prepayment review. To obtain consent, the Contractor must submit its request to place a provider on prepayment review via the MDHHS-OIG sFTP. Requests must be made using MDHHS-OIGs Prepayment Review Request template and at a minimum include:

i. Subject name, address, phone number, provider NPI and type, and any other identifying information;
ii. Date the Contractor plans to place the subject on prepayment review;
iii. The reason for the prepayment review (i.e., the risk(s) identified);
iv. The data or information relied upon in placing the provider on prepayment review (i.e., how the risk was identified);
v. The specific billing codes that will be subject to prepayment review; and
vi. The documentation to be reviewed by the Contractor prior to approval of the selected claims and how that review will mitigate the risk(s) identified.

6. Provision for written policies for all employees of the Contactor, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

Contractor must include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

7. Provision for the prompt referral of any potential Fraud that the Contractor identifies to MDHHS-OIG. The Contractor must have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected Fraud, Waste and Abuse activities.

    a. Contractor must refer all potential Contractor employee and provider Fraud via MDHHS-OIG's secure file transfer protocol (sFTP) using MDHHS-OIGs standard Fraud referral template.

        i. Contractor questions regarding whether suspicions should be classified as Fraud, Waste and Abuse should be presented to MDHHS-OIG for clarification.

            (i)i Contractor provider Fraud referrals must be made using the MDHHS-OIG MCO Fraud Referral template and, at a minimum, include the following information:

                - Subject (name, NPI, address, provider type)
                - Source/origination of complaint
                - Date reported to Contractor
                - Description of suspected misconduct, with specific details including:
                    - Category of service
                    - Factual explanation of the allegation
                    - Specific Medicaid statutes, rules, regulations and/or policies violated
                    - Date(s) of conduct
                - Amount paid to provider during the past three (3) years or during the period of alleged misconduct, whichever is greater
                - Copies of all provider enrollments agreement(s)
                - Relevant Contractor encounter data
                - All communications between the Contractor and provider concerning conduct at issue
                - Contact information for Contractor staff person with practical knowledge of workings of the relevant program
                - Sample/exposed dollar amount [when available]

            (i)ii Immediately upon making a referral, the Contractor must cease all efforts to take adverse action against or collect overpayments from referred provider until it is directed to do so by MDHHS-OIG.

    b. Contractor must refer all potential Enrollee Fraud, Waste or Abuse that the Contractor identifies to MDHHS through https://mdhhs.michigan.gov/Fraud/ or its Welfare Fraud Hotline (800-222-8558).

In addition, the Contractor must report all of Fraud, Waste and Abuse referrals made to MDHHS on their quarterly submission described in Section XVIII.B of this Contract.

8. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23.

   A credible allegation of Fraud may be an allegation, which has been verified by the State, from any source, including, but not limited to the following:

   a. Fraud hotline complaints;

   b. Claims data mining; or

   c. Patterns identified through provider audits, civil false claims cases and law enforcement investigations.

   Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

9. Provision for the Contractor to include available methods (e.g., toll-free telephone numbers, websites, etc.) for reporting Fraud, Waste, and Abuse to the Contractor and MDHHS-OIG in employee, member, and provider communications annually. Contractor must indicate that reporting of Fraud, Waste, and Abuse may be made anonymously.

B. Reporting – Contractor must send all program integrity notifications via the MDHHS-OIG sFTP and all program integrity reports to the Managed Care Plan Division sFTP. The Contractor must follow the procedures and examples contained within the MDHHS-OIG quarterly submission forms and accompanying guidance document. See Appendix 18 for the listing of notification forms and reports and their respective due dates:

1. On a quarterly basis, the Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing the program integrity activities performed by the Contractor, as required by Section XVIII.A of this Contract, during the previous quarter. This report must include any improper payments identified and overpayments recovered by the Contractor during the course of its program integrity activities. It is understood that identified overpayments may not be recovered during the same reporting time period.

2. Notwithstanding the obligation to report suspicions of provider and subcontractor Fraud directly to MDHHS-OIG as required by this Contract, Contractor must, on a quarterly basis, submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing all allegations of provider and subcontractor Fraud received and reviewed by the Contractor during the previous quarter.

3. On an annual basis, Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, an annual Program Integrity Plan for Michigan Medicaid. The plan must include the Contractors plan of activities for the upcoming year including, but not limited to, the following activities:

   a. Data analytics and algorithms;

   b. Clinical reviews;

   c. Audits;

   d. Investigations planned;

   e. Services requiring prior authorization;

   f. Payment edits and audits;

g. Provider credentialing; and

h. TPL identification.

4. Pursuant to 42 CFR § 438.608(d)(3), on an annual basis, Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report must include a report of all provider and service-specific program integrity activities such as, but not limited to, the following activities:

   a. Data analytics and algorithms;

   b. Clinical reviews;

   c. Audits;

   d. Investigations;

   e. Authorization denials;

   f. Payment edits and audits;

   g. Provider credentialing outcomes and terminations; and

   h. TPL outcomes.

   Pursuant to 42 CFR § 438.606, the annual Program Integrity Report must be certified by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification must attest that, based on best information, knowledge and belief, the information specified is accurate, complete and truthful.

5. Any excluded individuals and entities discovered in the screening described in Section XVIII.H of this Contract, including the provider applications, credentialing and credentialing processed, must be reported to the federal HHS OIG and MDHHS-OIG, in a format determined by MDHHS-OIG, within 20 Business Days of discovery.

6. Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a Quarterly Provider Disenrollment Log including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; provider terminations for convenience; and providers who self-terminated.

7. Compliance Review Score – Contractor will be scored based on the quantity and quality of the quarterly reports submitted to MDHHS-OIG.

   a. Contractor will receive a score of fail for any compliance review quarter where it has not initiated any program integrity activities, as required by Section XVIII.A of this Contract, during the previous quarter.

   b. Contractor will receive a score of fail for any compliance review quarter where it has not complied with the MDHHS-OIG quarterly submission form content requirements and/or the accompanying guidance document.

   c. Contractor will receive a score of incomplete for any compliance review quarter where it has not complied with the deliverable due dates.

C. Availability of Records – Contractor must cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation must include providing, upon request, information, access to records and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

1. Contractor and its providers, subcontractors and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section XVIII of this Contract.

2. Contractor must ensure within its own organization and pursuant to any agreement the Contractor may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid, that MDHHS representatives and authorized federal and State personnel, including, but not limited to MDHHS-OIG, the Michigan Department of Attorney General, the US Department of Health and Human Services, US Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized State or federal agency must have immediate and complete access to all records pertaining to services provided to Michigan Medicaid Enrollees, without first obtaining authorization from the Enrollee to disclose such information (42 CFR § 455.21 and 42 CFR § 431.107).

3. Contractor and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438.5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610) available at the Contractor's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

   a. Access will be either through on-site review of records or by any other means at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time.

      i. Upon request, the Contractor, its provider or subcontractor must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate MDHHS-OIG or other state or federal agency.

   b. Contractor must send all requested records to MDHHS-OIG within 30 Business Days of request unless otherwise specified by MDHHS or MDHHS rules and regulations.

c. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records must be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and 10 years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

D. Provider Manual and Bulletins – Contractor must issue Provider Manual and Bulletins or other means of Provider communication to the providers of medical, behavioral, dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations and special requirements to ensure all Contract requirements are being met.

The Contractor may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

1. The Contractor's provider manual must provide all of its Providers with, at a minimum, the following information:

a. Description of the Michigan Medicaid managed care program and covered populations;

b. Scope of Benefits;

c. Covered Services;

d. Emergency services responsibilities;

e. Grievance/appeal procedures for both Enrollee and provider;

f. Medical necessity standards and clinical practice guidelines;

g. The Contractor's policies and procedures including, at a minimum, the following information:

i. Policies regarding provider enrollment and participation;

ii. Policies detailing coverage and limits for all covered services;

iii. Policies and instructions for billing and reimbursement for all covered services;

iv. Policies regarding record retention;

v. Policies regarding Fraud, Waste and Abuse;

vi. Policies and instructions regarding how to verify beneficiary eligibility;

h. Primary Care Physician responsibilities;

i. Requirements regarding background checks;

j. Other provider/subcontractors' responsibilities;

k. Prior authorization and referral procedures;

l. Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

m. Medical records standards;

n. Payment policies;

o. Enrollee rights and responsibilities.

p. Self-reporting mechanisms and polices as cited in XVIII.A.2.c.

2. Contractor must review its Provider Manual, Bulletins and all Provider policies and procedures at least annually to ensure that Contractor's current practices and Contract requirements are reflected in the written policies and procedures.

3. Contractor must submit Provider Manual, Bulletin and or other means of Provider communications to MDHHS-OIG upon request.

E. Provider Enrollment Agreements-Contractor must submit its Provider Enrollment Agreements to MDHHS-OIG upon request.

F. Affiliations with Debarred or Suspended Persons – Pursuant to 42 CFR § 438.610:

1. Contractor must not knowingly have a director, officer, partner, managing employee or person with beneficial ownership of more than 5% of the Contractor's equity who has been are currently debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

2. Contractor must not knowingly have a director, officer, partner or person with beneficial ownership of more than 5% of the Contractor's equity who is affiliated (as defined in the Federal Acquisition Regulation at 48 CFR § 2.101) with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

3. Contractor must not have a Network Provider or person with an employment, consulting or any other contractual agreement with a debarred or suspended person or entity for the provision of items or services that are significant and material to this Contract.

4. Contractor must agree and certify it does not employ or contract, directly or indirectly, with:

a. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

b. Any individual or entity discharged or suspended from doing business with Michigan Medicaid; or

c. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

5. MDHHS may refuse to enter into or renew a contract with the 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 Section XVIII.G of this contract.

G. Disclosure by Managed Care Entities: Information on Ownership and Control – Pursuant to 42 CFR § 455.104: MDHHS will review ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors.

1. Contractor must provide to MDHHS the following disclosures:

   a. The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5% or more of the Contractor's equity (or, in the case of a Subcontractor's disclosure, 5% or more of the Subcontractor's equity);

   b. The identification of any person or corporation with an ownership interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the Subcontractor equal to 5% of the Subcontractor's assets);

   c. The name, address, date of birth and Social Security Number of any managing employee of the Managed Care organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e., member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

2. The disclosures must include the following:

   a. The name, address and financial statement(s) of any person (individual or corporation) that has 5% or more ownership or control interest in the Contractor.

   b. The name and address of any person (individual or corporation) that has 5% or more ownership or control interest in any of the Contractor's Subcontractors.

   c. Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor's employee such as a spouse, parent, child or siblings; or is related to one of the Contractor's officers, directors or other owners.

   d. Indicate whether the individual/entity with an ownership or control interest owns 5% or greater in any other organizations.

   e. The address for corporate entities must include as applicable primary business address, every business location and P.O. Box address.

   f. Date of birth and Social Security Number (in the case of an individual).

   g. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Managed Care Organization or its Subcontractor.

3. The Contractor must terminate or deny network participation if a provider, or any person with 5% or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by MDHHS, within 30 Days when requested by MDHHS or any authorized federal agency.

4. Disclosures from the Contractor are due to MDHHS at any of the following times:

a. When the Contractor submits a proposal in accordance with an MDHHS procurement process.

b. When the Contractor executes the Contract with MDHHS.

c. Upon renewal or extension of the Contract.

d. Within 35 Days after any change in ownership of the Contractor.

e. Upon request by MDHHS.

5. All required disclosures under this subsection must be made to MDHHS, the Secretary of the US Department of Health and Human Services and the Inspector General of the US Department of Health and Human Services in the format developed by the requestor. Failure to provide required information may lead to sanctions including withholding of capitation payment. Federal financial participation is not available for entities that do not comply with disclosures, therefore, 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.

H. Excluded Individuals and Entities – Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person. (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR § 455.104, 42 CFR § 455.106, and 42 CFR § 1001.1901(b)). Contractor must monitor its Network Providers for excluded individuals and entities by requiring its Network Providers be actively enrolled with the Michigan Medicaid Program.

1. Contractor must not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor must immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

2. Contractor is prohibited from entering into any employment, contractual and control relationships with any excluded individual or entity.

3. Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (SSA section 1128A(a)(6)).

4. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5% or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR § 455.104(a), and 42 CFR § 1001.1001(a)(1)).

5. Contractor must immediately terminate all beneficial, employment, and contractual and control relationships with any individual or entity excluded from participation by MDHHS.

I. Network Provider Medicaid Enrollment – Pursuant to 42 CFR § 438.602(b)(1), all Network Providers of the Contractor must enroll with the Michigan Medicaid Program.

1. The State will screen and enroll, and periodically revalidate all enrolled Medicaid providers.

2. Contractor must require all its Network Providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.

a. Contractor may execute Network Provider agreements, pending the outcome of screening, enrollment and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees.

3. Contractor must verify and monitor its Network Providers' Medicaid enrollment.

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 provide the following positions:

a. Executive Director/Chief Executive Officer (CEO)

b. Medical Director

c. Quality Improvement Director

d. Chief Financial Officer (CFO)

e. Management Information System Director

f. Compliance Officer

g. Member Services Director

h. Provider Services Director

i. Grievance and Appeals Coordinator

j. Medicaid Liaison

k. MIS Liaison

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.

4. Contractor must employ or contract with sufficient, clinically qualified administrative staff to perform utilization activities for dental services required in this contract.

5. Contractor must ensure that all requested and/or appropriate personnel attend or are made available during MDHHS onsite visitations with Contractor.

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 (QAPI).
    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, Waste and Abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

7. Member Services Director

   Coordination of communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate.

   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.

G. In accordance with 42 CFR 438.602(i) and Medicaid policy, Contractor's business must be located within the United States. Contractor's failure to meet this requirement is cause for termination as described in the Standard Contract Terms.

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

1. Health maintenance organization's governing body must include no less than 1 individual who represents the health maintenance organization's membership.
2. A Health Maintenance Organization that is under a contract with this state to provide medical services authorized under subchapter XIX or XXI of the Social

Security Act, 42 USC1396 to 1396 w-1 5 and 1397aa to 1397mm, must comply with either of the following requirements:

a. A minimum of 1/3 of its governing body must be representatives of its membership consisting of Medicaid Enrollees of the organization who are not compensated officers, employees or other individuals responsible for the conduct of, or financially interested in, the organization's affairs or;

b. The health maintenance organization must establish a consumer advisory council that reports to the governing body. The consumer advisory council must include at least 1 Medicaid Enrollee, one family member or legal guardian of an Enrollee and one consumer advocate.

3. A health maintenance organization must meet at least quarterly unless specifically exempted from this requirement by the Director.

4. Contractor must actively attempt to recruit CSHCS beneficiary parents/guardians to participate in its non-compensated governing body or consumer advisory council.

E. Governing Body Procedures

Contractor must have written policies and procedures for governing body detailing, at a minimum, the following:

1. The length of the term for board members
2. Filling of vacancies
3. 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.

G. Consumer Advisory Council

If the Contractor plans to establish a consumer advisory council, prior to implementation, Contractor must submit written policies and procedures for the consumer advisory council detailing, at a minimum, the following:

1. How council members are chosen
2. Duties of the council members
3. The length of term for council members
4. Filling of vacancies
5. How often the council reports to the governing body and how minutes or other reports will be shared with MDHHS

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 Requirements, Classifications and Flowdown

Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to Subcontractors and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. If Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor must take corrective action, including when

appropriate, revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

I. Subcontractor Classifications

A. Category I: Health Benefit Managers (HBMs)

HBMs are entities that arrange for the provision of health services covered under this Contract, with the exclusion of transportation.

1. HBMscan 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
    e. Dental Benefit Managers
2. Contractor must notify MDHHS of a new Health Benefit Manager at least 30 Days prior to the effective date of the contract with the Health Benefit Manager.
3. The State reserves the right to approve or reject the Contractor's proposed use of a HBM.

B. 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.

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 (TPL), 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 at least 21 Days prior to the effective date of the contract with the Administrative Subcontractor.
3. The State reserves the right to approve or reject Contractor's proposed use of an Administrative Subcontractor.

C. Category III: 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 at least 30 Days prior to the effective date of the contract with the Subcontractor.

3. The State reserves the right to approve or reject the Contractor's proposed use of any Transportation Subcontractor.

4. 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.

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.

a. Contractor must monitor Subcontractor for compliance of all delegated Contract responsibilities, requirements and standards managed through the Subcontractor.

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, except as described in section 1.1., VI.D.19 of this Contract.
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 must not relieve Contractor of any obligations or performance required under this Contract.
6. Contractor's agreement with its Subcontractors must:
    a. Require the Subcontractor comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Contract provisions.
    b. Require the Subcontractor agree that the state, CMS, the DHHS Inspector General, the Comptroller General or their agents have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the state.
    c. Require the Subcontractor make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Enrollees.
    d. Require the Subcontractor agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    e. The state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

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)
5. QI Directors (bimonthly)

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. Financial Reports

1. DIFS Financial Reports: Contractor must submit the Annual NAIC financial statement and all financial reports required by DIFS.

2. Overpayment Recoveries: The Contractor must provide an annual report of overpayment recoveries as required in § 438.608(d)(3).
3. Contractor must submit financial reports in the format required by MDHHS and in the timeframe specified in in this contract including but not limited to Appendix 3 and compliance review requirements.
4. MDHHS may require monthly financial statements from the Contractor.
5. Contractor must submit data on the basis of which MDHHS:
    a. Certifies the actuarial soundness of capitation rates to under § 438.3, including base data described in § 438.5(c) that is generated by Contractor.
    b. Determines the compliance of Contractor with the medical loss ratio requirement described in § 438.8.
    c. Determines that Contractor has made adequate provision against the risk of insolvency as required under § 438.116.

B. Compliance Review Reporting

Contractor must submit all reports as required by this Contract for Compliance Review including, but not limited to:

1. Data Certification and Attestation 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.
2. 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
3. Health Plan Profile: Contractor must provide all information requested on the Health Plan Profile form provided by MDHHS and attach all required documents.
4. 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.
5. Appendix 18 Compliance Review-Program Integrity requirements.
6. All documents and items specified in the MDHHS Compliance Review Tool

C. 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

D. Encounter Data Submission

1. Contractor must submit Encounter Data to MDHHS in the form and manner described in 438.818.

2. 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.
3. Encounter records must be submitted monthly via electronic media in a HIPAA compliant format as specified by MDHHS.
4. Contractor 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.
5. 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.

E. 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. CMS Special Terms and Conditions of the 1115 Waiver Approvals
2. P.A. 208 of 2018
3. MDHHS Policy and Operational Process

I. Provider Race/Ethnicity Reporting

Contractor must with Providers and MDHHS to collect and report the race/ethnicity of their contracted Providers. Contractor must report the race/ethnicity of contracted Providers to MDHHS within the specified timeline.

J. The Contractor must submit to the State the following data:

1. Documentation described in § 438.207(b) on which MDHHS bases its certification that Contractor has complied with MDHHS' requirements for availability and accessibility of services, including the adequacy of the Provider Network, as set forth in § 438.206.

2. Information on ownership and control described in § 455.104 of as governed by § 438.230.

K. Contractor must submit any other data, documentation, or information relating to the performance of the entity's Program Integrity obligations required by MDHHS or the federal government.

L. Other Data Sources

MDHHS may develop other data sources and/or measures during the course of the Contract term. MDHHS will 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, except that MDHHS will not pay a Maternity Case Rate for Enrollees who are dually-eligible for Medicare and Medicaid.

C. Capitation Rates

1. MDHHS will establish actuarially sound capitation rates developed in accordance with the federal requirements for actuarial soundness (see Appendix 13). The accepted definition of Actuarial soundness is: Medicaid Capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government mandated assessments, fees, and taxes imposed by this state and the federal government including the Health Insurer fee that the contractor incurs and becomes obligated to pay under section 9010 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, due to its receipt of Medicaid premiums pursuant to the contract. For purposes of this subsection, the full cost of the Health Insurer Fee includes both the Health Insurer Fee and the allowance to reflect the federal and state income tax. 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:

    a. The annual financial filings of all Contractors.

    b. Relevant Medicaid FFS data.

    c. Relevant Contractor Encounter Data.

2. MDHHS will not consider any claims paid by the Contractor to a Network Provider, Out-of-Network Provider, Subcontractor or financial institution located outside the United States in the development of actuarially sound capitation rates.

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 Blind and Disabled, Temporary Assistance for Needy Families and Healthy Michigan Plan program categories, 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.

1. The State may deduct from whatever is owed Contractor on this Contract an amount sufficient to compensate the State for any damage resulting from termination or rescission.
2. Any payment to Contractor may be reduced or suspended when a provision of this Contract requires a payment or refund to the State or an adjustment of a payment to the Contractor.
3. If any failure of the Contractor to meet any requirement of this Contract results in the withholding of federal funds from the State, the State may withhold and retain an equivalent amount from payments to Contractor until such federal funds are released, in whole or in part, to the State, at which time the State will release to Contractor an amount equivalent to the amount of federal funds received by the State.

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 and in

compliance with 42 CFR 438.6(b). Contractor's performance will be measured during the rating period in which the withhold arrangement is applied.

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
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)
The Act	The Social Security Act
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.
Adverse Benefit Determination	An action or inaction by the Contractor including any of the following: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner, as defined by the MDHHS. 5. The failure of the Contractor to act within the timeframes provided in § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals. 6. For a resident of a Rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. 7. The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.
Alternative Formats	Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats must include, but not be limited to, Braille, large font, audio tape, video tape, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.
Appeal	Review by the Contractor of an Adverse Benefit Determination.
Beneficiary	Any person determined eligible for the Michigan Medical Assistance Program.
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.
Centers for Medicare and Medicaid Services (CMS)	The federal agency (and its designated agents) within the United States' Department of Health and Human Services responsible for federal oversight of the Medicaid, Medicare, and the Children's Health Insurance Program.
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 MHP.
Clean Claim	All claims as defined in 42 CFR §447.45 and MCL 400.111i.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
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.
Complaint	A communication by a Beneficiary or a Beneficiary's representative to the Contractor expressing a concern about care or service provided by the Contractor, dental provider or Transportation Subcontractor; presenting an issue with a request for remedy that can be resolved informally. Complaints may be oral or written.
Contract	A binding agreement entered into by the State of Michigan and the Contractor.
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 to Enrollees.

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.
Department of Insurance and Financial Services (DIFS)	Responsible for oversight of insurers, Health Maintenance Organizations (HMOs), and financial entities doing business in the State.
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)	Benefits defined in section 1905(r) of the Act including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.
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 Dental Services	Care for an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.
Emergency Services	Covered inpatient and outpatient services, including Behavioral Health Services, that are furnished to an Enrollee by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.
Encounter Data	Medical records containing detail for each enrollee encounter with a Provider for health services for which Contractor paid Providers for Covered Services.

Enrollee	Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in the Contractor's Medicaid Health Plan.
Enrollment Capacity	The number of Enrollees or Potential Enrollees that the Contractor can serve through its Provider Network under a Contract with the State. Enrollment Capacity is determined by MDHHS in consultation with Contractor based upon its Provider Network organizational capacity, available risk-based capital, and Contractor's ability to meet Network adequacy and access to care standards and requirements of this Contract.
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 three 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).
External Quality Review Organization (EQRO)	Agency that provides EQR data analysis and assessment.
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/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law (42 CFR § 455.2).
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) Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.
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 Care Provider (IHCP)	A healthcare program operated by the Indian Health Service (HIS) or by an Indian Tribe, Tribal Organization (otherwise known as I/T/U as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)
Indian Health Services/Tribal Health Centers/Urban Indian Organizations (I/T/U)	Health care providers specifically for Native Americans.
Inflationary Payments	Inflationary payments refer to any agreement a PBM may have with a manufacturer where the manufacturer agrees to a payment back to the PBM if a drug has inflation above an agreed upon level.
Initial Appointment	The first scheduled examination by Provider for a new patient admitted into the practice
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 months is not considered Initial Enrollment.
Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)	Care facilities specifically for persons with Intellectual Disabilities..
LARA	Michigan Department of 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	Contractor must seek MDHHS' approval of 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.
Michigan Compiled Laws (MCL)	The official codification of statutes for the State of Michigan.
MED	Medicare Exclusion Database
Medicaid	A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.
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 Assistance Program	The Michigan Medicaid program authorized under Title XIX of the Social Security Act.

Medical Necessity or Medically Necessary	Covered Services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly.
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.
Non-Urgent Symptomatic Care	An Enrollee encounter with a Provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention.
National Association of Insurance Commissioners (NAIC)	The US standard-setting and regulatory support organization whose main responsibility is to protect the interests of insurance consumers.
NPPES	National Plan and Provider Enumeration System
National Committee for Quality Assurance (NCQA)	A private, 501©(3) not-for-profit organization dedicated to improving health care quality.
National Provider Identifier (NPI)	A unique 10-digit identification number issued to heath care providers in the United States by CMS.
Out-of-Network	Covered Services rendered to a beneficiary by a provider who is not part of the Contractor's Provider Network.
Overpayment	The amount paid by the Medicaid agency or its Contractors to a provider which is in excess of the amount that is allowable for services furnished.
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.
PCMH Initiative	MDHHS-led Statewide program centered on further spreading the PCMH model of care, advancing primary care capabilities, making measurable improvement in quality of care, health outcomes, utilization/cost and patient satisfaction, and increasing PCMH participation in alternative payment methodologies linked to provider performance. PCMH Initiative participating providers are selected through an open, competitive application process which ensures practices adhere to a consistent set of participation requirements. PCMH Initiative monitors provider compliance with participation requirements. Provider performance metrics include quality of care, health outcome, utilization, cost of care and care management/care coordination performance measures and benchmarks as well as quality improvement activities that support and substantially align with MDHHS Medicaid managed care quality objectives.
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 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 oral and physical health and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.
Post-stabilization Care Services	Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, to improve of resolve the Enrollee's condition.
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 the Contractor's MHP.
Prepaid Inpatient Health Plan (PIHP)	Provides behavioral health services to Enrollees excluding the outpatient behavioral health services for Enrollees in this Contract as described in Appendix 7.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
Preventive Services (Dental)	Preventive dental services include services such as oral evaluations, routine cleanings, x-rays, sealants and fluoride treatments.
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 (or Network Provider)	An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any subcontractor, for the delivery of Covered Services to Enrollees.
Provider Contract	An agreement between the Contractor and a Provider for the provision of services under the Contract.
Provider Network	The collective group of Network Providers who have entered into Provider Contracts with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to, physical, behavioral, pharmacy, and ancillary service providers.
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
Rebates	Rebates include manufacturer fees and administration fees for rebating
Recoupment	Any formal action by the State or its contractors to initiate recovery of an overpayment made to a Provider.

Region	Groupings of contiguous counties defined and numbered 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
Risk Mitigation and Action Plan	For the purposes of Third-Party Liability, a Risk Mitigation and Action Plan is a document that will be provided by the Medicaid Health Plan outlining the actions the Medicaid Health Plan will take to address risks identified by MDHHS. Risks are issues that will affect a Medicaid Health Plan's ability to meet the minimum TPL requirements required by contract, federal, or state law in order to reduce the likelihood of an adverse State or Federal TPL audit finding.
Routine Care (Medical)	An Enrollee encounter with a Provider that is not associated with any presenting medical signs. Examples include well-child visits and annual adult physical examinations.
Routine Care (Dental)	Dental services that include the diagnosis and treatment of oral health conditions to prevent deterioration to a more severe level or minimize/reduce the risk of development of dental disease or the need for more complex dental treatment. Examples include but are not limited to services such as fillings and space maintainers
Rural Health Clinic(RHC)	Public, non-profit or for-profit healthcare facility located in rural medically underserved area. In Michigan, RHCs are certified by LARA to participate in Medicare and Medicaid programs under an agreement with CMS. The current RHCs in Michigan are listed at the following website: http://www.michigan.gov/documents/lara/MI_Rural_Health_Clinic_Directory_2-2016_515599_7.pdf
Rural	Rural is defined as any county not designated as metropolitan or outlying metropolitan by the Office of Management and Budget.
SAM	System for Award Management (www.sam.gov)
Service Authorization Decision	Contractor's written response to Enrollee's service authorization request provided as expeditiously as the Enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following the receipt of the request for service, with a possible extension of up to 14 additional calendar days if---(i) The Enrollee, or the Provider requests an extension; or (ii) Contractor justifies a need for additional information and how the extension is in the Enrollee's best interest.
Service Authorization Request	a managed care Enrollee's request for the provision of a service.
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	The State of Michigan, including any departments, divisions, agencies, offices, commissions, officers, employees and agents.
State Fair Hearing	An impartial review by MDHHS of a decision made by the Contractor that the Enrollee believes is inappropriate.
Subcontract	A written contract between the Contractor and a third party to perform any of the Contractor's administrative obligations under this Contract, excluding contracts with Network Providers.
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
Urgent Care (Dental)	Services required to prevent serious deterioration of oral health following the onset of an unforeseen condition or injury.
Urgent Care (Medical)	Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.
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.
Waste	The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.
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.
Annual Financial	Medical Loss Ratio	85%	Below 85%: Corrective Action Plan	If the Contractor fails to meet the Medical Loss Ratio threshold, the Contractor must submit to MDHHS a corrective action plan that describes its plan to come into compliance with the threshold requirement inclusive of Contractor tasks and timeframes.
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

FY 2020 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

These reports must be submitted in addition to contract compliance review submission requirements.

All reports must be **shared** electronically via the **MDHHS File Transfer Application**.
Exceptions are the encounter data, provider file, and PCP Submission file which are submitted electronically via the DEG.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Medicaid Health Equity Template	8/15/20	1/1/19 – 12/31/19	Use the template provided by MDHHS in March
MDHHS Health Plan Abortion Report	10/5/20	10/1/2019-9/30/2020	MSA-0128 accompanied with all MSA-4240s
DUR Report	Due Date to be announced to MHPs based upon additional CMS information to the State.		Contract 1.1 VI.D.
MLR Report	6/1/20	10/1/2018-9/30/2019	MDHHS MLR Template
Quarterly Submissions (Previous months reporting)			
Financial	March 15 May 15 August 15 November 15	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	NAIC and DIFS
Grievance/Appeal	January 30 April 30 July 30 October 30	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	MSA-0131: Medicaid Health Plan Grievance/Appeal Summary Report
Healthy Michigan Plan Grievance/Appeals	January 30 April 30 July 30 October 30	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	
Third Party Collection	March 15 May 15 August 15 November 15	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	Report on separate sheet and send with NAIC
Third Party Recovery	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	MDHHS Format Contract XVII.G
Monthly Submissions			

Report Reference	Due Date	Period Covered	Instructions/Format
Claims Processing	30 Days after end of the month NOT last day of month	• Data covers previous month • i.e., data for 2/17 due by 3/30/17	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/17 due by 2/15/17	837 Format NCPDP Format
Provider Files (4275)	The last Thursday of each month by noon.	• Submit all Providers contracted with the plan on the date of submission • Submit one file, utilizing the single provider ID.	4275 layout and file edits distributed by MDHHS
Flint Outreach Report	The 1st of each month		Flint Outreach Excel Layout
Weekly Submissions			
PCP Submission Files (5284)	Weekly	• 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
Healthy Behaviors File (5944)	Weekly	• Once the appointment is complete, plans will have 60 Days to transmit data on completed HRAs and/or Wellness Programs to MDHHS via the 5944 file layout.	5944 Layout and file edits distributed by MDHHS

MEDICAID MANAGED CARE
Medicaid Health Plans
(Effective October 1, 2019 – September 30, 2020)

Appendix 4 - PERFORMANCE MONITORING STANDARDS

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 the following:

- MDHHS Administrative Measures
- Healthy Michigan Plan (HMP) Measures
- MDHHS Dental Measures
- Health Equity HEDIS
- CMS Core Set Measures / HEDIS / Managed Care Quality Measures

For each performance area, the following categories are identified: Measure, Goal, Minimum Standard for each measure, Data Source and Monitoring Intervals, (annually, quarterly, monthly)

Minimum performance monitoring standards for FY 2020 are included in this document. Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract.

MDHHS Administrative Measures, HMP Measures, and MDHHS Dental Measures are all run with custom coded queries.

Measures in the Health Equity HEDIS, CMS Core Set, HEDIS, and Managed Care Quality sections that are noted with an asterisk (*) are all run with Symmetry except the following measures which are custom coded: Live Births Weighing Less than 2,500 Grams, Blood Lead Testing, and Non-Emergent Medical Transportation (NEMT) Encounter Submission.

All Health Equity HEDIS, CMS Core Set, HEDIS, and Managed Care Quality measures will be "Informational Only" for FY 20 and part of FY 21. Health Plans will not be held to these standards until the April 2021 Performance Monitoring Report.

MDHHS ADMINISTRATIVE MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Customer Services: **Enrollee Complaints**	Plan will have minimal member contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate ≤0.15 per 1,000 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
Pharmacy Encounter Data Reporting	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 submission to MI Enrolls by the last Thursday of the month	Timely and Accurate submission	MI Enrolls	Monthly

HEALTHY MICHIGAN PLAN (HMP)

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Adults' Generic Drug Utilization	Adult Enrollees who had a generic prescription filled during the measurement period	≥80%	MDHHS Data Warehouse	Quarterly
Completion of Annual Health Risk Assessment (HRA)	HMP members who had an HRA completed within the last 12 months.	≥12%	MDHHS Data Warehouse	Quarterly
Outreach and Engagement to Facilitate Entry to Primary Care	HMP members 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	≥50%	MDHHS Data Warehouse	Quarterly
Consistently Fail to Pay (CFP) Status	HMP members who: 1. Transitioned from non-CFP status to CFP status during the last quarter of the measurement period. -or- 2. Transitioned from CFP status to non-CFP status during the last quarter of the measurement period. A standard is set for each FPL (≤ 100% and > 100%) for both members transitioning into CFP status and for members transitioning out of CFP status, producing a total of four (4) standards for this measure.	FPL >100%: ≤30% FPL ≤100%: ≤7% Members transitioning from non-CFP Status into CFP status (Reverse Measure) FPL >100%: ≥ 2% FPL ≤100%: ≥ 2% Members transitioning out of CFP Status into non-CFP status	MDHHS Data Warehouse	Quarterly

MDHHS DENTAL MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Diagnostic Dental Services	Members who received at least one diagnostic dental service within the measurement period.	50th percentile: ≥30%	MDHHS Data Warehouse	Quarterly
Preventive Dental Services	Members who received at least one preventive dental service within the measurement period.	50th percentile: ≥17%	MDHHS Data Warehouse	Quarterly
Restorative (Dental Fillings) Services	Members who received at least one restorative (dental fillings) dental service within the measurement period.	50th percentile: ≥14%+	MDHHS Data Warehouse	Quarterly
Comprehensive Diabetes Care: Diagnostic Dental Exam	Healthy Michigan Plan members with Type 1 or Type 2 diabetes, who had at least one diagnostic dental service within the measurement period.	Informational Only	MDHHS Data Warehouse	Quarterly
Comprehensive Diabetes Care: Preventive Dental Visit	Healthy Michigan Plan members with Type 1 or Type 2 diabetes, who had at least one preventive dental service within the measurement period.	Informational Only	MDHHS Data Warehouse	Quarterly
Comprehensive Diabetes Care: Restorative Dental Visit	Healthy Michigan Plan members with Type 1 or Type 2 diabetes, who had at least one restorative dental service within the measurement period.	Informational Only	MDHHS Data Warehouse	Quarterly
Diagnostic Dental Visits in Pregnant Women	Pregnant women who received at least one diagnostic dental service during their pregnancy or 90 days postpartum.	Informational Only	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Preventive Dental Visits in Pregnant Women	Pregnant women who received at least one preventive dental service during their pregnancy or 90 days postpartum.	Informational Only	MDHHS Data Warehouse	Quarterly
Restorative Dental Visits in Pregnant Women	Pregnant members who received at least one restorative dental service during their pregnancy or 90 days postpartum.	Informational Only	MDHHS Data Warehouse	Quarterly
Adults: Any Dental Visit	Healthy Michigan Plan members who had at least one dental service within the measurement period	Informational Only	MDHHS Data Warehouse	Quarterly

+ If the Restorative (Dental fillings) rate is less than the 50th percentile and the MHP has been performing at the 75th percentile for Preventive Dental Services, it has achieved the minimum required benchmark for Restorative (Dental fillings) measure.

HEALTH EQUITY HEDIS MEASURES

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.	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly
***Chlamydia Screening in Women (Total)**	Women enrolled in a health plan, ages 16 to 24, who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly
***Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing**	Members ages 18 to 75, with Type 1 or Type 2 diabetes, who had an HbA1c test.	Index of Disparity at or below 5%	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: 1. Women ages 21 to 64 who had cervical cytology performed every three (3) years 2. Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly

(*) indicates that this measure is run with symmetry

The Index of Disparity (D) is a nationally used and well-vetted measure to assess differences across groups. It adds up all of the differences between subpopulations and the total population then averages them out to a total degree of disparity, called the Index of Disparity. The formula can be used for a variety of subpopulations (racial/ethnic groups, income levels, education levels, etc.) and can be applied to any measure. The formula is below. $ID=(\sum|r(n)-R| /n) / R*100$
r=Subpopulation rate, R=Total population rate, n=number of subpopulations. The ID is calculated by finding the absolute difference (i.e. no negative numbers) between each subpopulation rate and the total population rate.

CMS CORE SET MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
***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	≥31% First year of life ≥40% Second year of life ≥31% Third year of life	MDHHS Data Warehouse	Monthly
Live Births Weighing Less Than 2,500 Grams (Low Birth Weight)	The percentage of live births that weighed less than 2,500 grams during the measurement period.	≤8% (Reverse Measure)	MDHHS Data Warehouse	Quarterly
***Diabetes Short-Term Complications Admission Rate**	The rate of members in a health plan ages 18+ who were discharged for diabetes short-term complications per 100,000 member months	≤18% (Reverse Measure)	MDHHS Data Warehouse	Quarterly
***Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	The rate of members in a health plan ages 40+ who were discharged for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months	≤70% (Reverse Measure)	MDHHS Data Warehouse	Quarterly
***Heart Failure Admission Rate**	The rate of members in a health plan ages 18+ who were discharged for heart failure per 100,000 member months	≤21% (Reverse Measure)	MDHHS Data Warehouse	Quarterly
***Asthma in Younger Adults Admission Rate**	The rate of members in a health plan, ages 18 to 39 who were discharged for asthma 100,000 member months	≤5% (Reverse Measure)	MDHHS Data Warehouse	Quarterly

(*) indicates that this measure is run with Symmetry

HEDIS MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
***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	≥63%	MDHHS Data Warehouse	Quarterly
***Adolescent Well Care Visits**	Members ages 12 to 21 with at least one well care visit during the measurement year.	≥57%	MDHHS Data Warehouse	Quarterly

MANAGED CARE QUALITY MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥81%	MDHHS Data Warehouse	Quarterly
Non-Emergent Medical Transportation (NEMT) Encounter Submissions	Data submission using appropriate NEMT codes and appropriate provider ID for MA-MC, HMP-MC, and CSHCS-MC	Informational Only	MDHHS Data Warehouse	Quarterly

(*) indicates that this measure is run with Symmetry

APPENDIX 5a: Performance Bonus Template

Medicaid Health Plan	FY20 Performance Bonus Measures Template		2019 NCQA Medicaid Percentiles National: HMO Average		
Maintenance					
Access to Care Measures - 2020 HEDIS	**2020 HEDIS Rate**	**90th Percentile - 2 points 75th Percentile - 1 point 50th Percentile - 0.5 points**	50th Percentile	75th Percentile	90th Percentile
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years					
Improvement					
Improvement	**2020 HEDIS Rate**	**90th Percentile - 4 points 75th Percentile - 3 points 50th Percentile - 2 points Stat. Sig. Impr. - 1 point**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Prenatal and Postpartum Care—Timeliness of Prenatal Care Controlling High Blood Pressure Breast Cancer Screening Adolescent Well-Care Visits Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg					
Plan-Specific					
Medicaid Health Plan	**FY20 Performance Bonus Measures Template**				
Plan-Specific Measures	**2020 Rate**	**90th Percentile - 4 points 75th Percentile - 3 points 50th Percentile - 2 points Stat. Sig. Impr. - 1 point**	**50th Percentile**	**75th Percentile**	**90th Percentile**
See: attachment					
Plan-Specific Measures - Health Equity	**2020 Rate**	**Stat. Sig. Impr. - 2 points**	**50th Percentile**	**75th Percentile**	**90th Percentile**
See: attachment					

CAHPS				
2020 CAHPS	**2020 CAHPS Rate**	**90th Percentile - 2 points** **75th Percentile - 1 points**	**75th Percentile**	**90th Percentile**
Adult				
Getting Care Quickly Composite Tobacco Cessation Strategies				
Child				
Getting Needed Care Composite Customer Service Composite				
Healthy Michigan Plan				
Health Plan Rating (9+10) Tobacco Cessation Strategies				

Medicaid Health Plan	**FY20 Performance Bonus Measures Template**	
Compliance Review - 2020	**Score**	**96% - 100% (10 pts)** **95% - 91% (9 pts)** **90% - 86% (8 pts)** **85% - 81% (7 pts)** **80% - 76% (6 pts)**
Overall Pass **The Overall Pass score in this template does not include the score from criterion 4.9 PMR Review"*		
Point Summary	**Possible Points**	**Health Plan Points**
Maintenance Measures (13.89%)	**10**	
Improvement Measures (27.78%)	**20**	
Plan-Specific Improvement Measures (22.22%)	**16**	
Health Equity Measures (5.56%)	**4**	
Survey Measures (CAHPS) (16.67%)	**12**	**0**
Compliance Review (13.89%)	**10**	
Performance Bonus Template Score	**72**	
Note: All sections points will be weighed by total Medicaid member months		

APPENDIX 5a Attachment

PLAN	Measure 1	Measure 2	Measure 3	Measure 4
AET	Prenatal and Postpartum Care— Postpartum Care	Lead Screening in Children	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Appropriate Testing for Children With Pharyngitis
BCC	Prenatal and Postpartum Care—Postpartum Care	Asthma Medication Ratio—Total	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Diabetes Monitoring for People With Diabetes and Schizophrenia
HAR	Comprehensive Diabetes Care— Eye Exam	Prenatal and Postpartum Care—Postpartum Care	Lead Screening in Children	Appropriate Testing for Children With Pharyngitis
MCL	Chlamydia Screening in Women—Ages 21 to 24 Years	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Appropriate Testing for Children With Pharyngitis
MER	Appropriate Testing for Children With Pharyngitis	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Diabetes Monitoring for People With Diabetes and Schizophrenia
HAP	Comprehensive Diabetes Care— Eye Exam	Prenatal and Postpartum Care—Postpartum Care	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Chlamydia Screening in Women—Total
MOL	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Asthma Medication Ratio—Total	Appropriate Testing for Children With Pharyngitis	Appropriate Treatment for Children With Upper Respiratory Infection
PRI	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Appropriate Testing for Children With Pharyngitis	Diabetes Monitoring for People With Diabetes and Schizophrenia
THC	Comprehensive Diabetes Care— Eye Exam	Prenatal and Postpartum Care—Postpartum Care	Lead Screening in Children	Appropriate Testing for Children With Pharyngitis
UNI	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Appropriate Treatment for Children With Upper Respiratory Infection	Appropriate Testing for Children With Pharyngitis	Adherence to Antipsychotic Medications for Individuals With Schizophrenia
UPP	Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Appropriate Testing for Children With Pharyngitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Plan	Health Equity	
	Measure 1	Measure 2
AET	Comprehensive Diabetes Care — HbAlc Testing	Cervical Cancer Screening
BCC	Comprehensive Diabetes Care — HbAlc Testing	Cervical Cancer Screening
HAR	Cervical Cancer Screening	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
MCL	Prenatal and Postpartum Care—Postpartum Care	Cervical Cancer Screening
MER	Cervical Cancer Screening	Prenatal and Postpartum Care—Postpartum Care
HAP	Comprehensive Diabetes Care — HbAlc Testing	Cervical Cancer Screening
MOL	Cervical Cancer Screening	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
PRI	Cervical Cancer Screening	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
THC	Comprehensive Diabetes Care — HbAlc Testing	Cervical Cancer Screening
UNI	Cervical Cancer Screening	Prenatal and Postpartum Care—Postpartum Care
UPP	Cervical Cancer Screening	Chlamydia Screening

APPENDIX 5b

2019 Pay for Performance
Population Health Management Intervention

OVERIEW

An individual's health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. Education, nutrition, transportation, and other dynamics are examples of social determinants of health that collectively influence health outcomes.

Housing stability was a top issue associated with high and super utilizers in the 2014 ED Utilization Symposium report submitted by MDHHS to the State Legislature. Homelessness was also the focus of a 2016 engagement between MDHHS and the National Governor's Association (NGA) to determine the relationship between housing stability and healthcare costs. In 2018, MDHHS will be launching a pilot project to address the integration between healthcare, housing, and Medicaid.

PURPOSE

The purpose of Population Health Management Intervention is to improve the health of the Michigan Medicaid population and to address Social Determinants of Health. The Medicaid Health Plans (MHPs) annually report their initiatives to MDHHS.

SUBMISSION AND SCORING

There are four forms the health plans must complete: 1) Baseline Analysis; 2) Intervention Proposal; 3) Intervention Implementation and Timeline Form; and 4) Intervention Reporting.

- **Baseline Analysis:**
  The purpose of the Baseline Analysis activity is to develop an in-depth understanding of the MHPs population that includes a review of literature; data collection, gathering of member input and analysis.

- **Intervention Proposal:**
  The purpose of the Intervention Proposal activity is to develop population health management interventions that target findings from the baseline analysis.

- **Intervention Reporting:**
  The purpose of the Intervention Report is to report the results of the intervention and ongoing assessments at 6 month intervals: 6 months, 12 months and 18 months.

There are two submission dates for the Baseline Analysis and the Intervention Proposal forms, as these submissions must be approved by MDHHS. The first/review submission date allows the Quality Improvement and Program Development (QIPD) Staff to review and provide feedback to the Plans, allowing revisions (if needed) before submitting for final MDHHS approved submission date.

Questions or comments about the FY19-FY20 Population Health Management Focus Bonus submissions and scoring should be directed to the MDHHS Quality Analyst (QA), Ashley Edwards at: EdwardsA11@michigan.gov.

PROJECT TIMELINE

FY 18 DELIVERABLES	DEADLINES	POINTS
A. BASELINE ANALYSIS FORM		
Complete Sections I. and II. of the Baseline Analysis Reporting Form:	PRE-Submission: 9/14/2018 Technical Assistance 10/15/2018 FINAL Submission: 11/15/2018	5
2. Initial Analysis Report - Table:1 Initial Population Health Management Data Collection		5
3. Plan for gathering member Input		5
4. Barrier and gap analysis plan		5
FY 18 TOTAL		**20**
FY 19 DELIVERABLES	**DEADLINES**	**POINTS**
B. INTERVENTION PROPOSAL FORM*		
Complete Sections in the Intervention Proposal Form:	PRE-Submission: 3/15/2019 Technical Assistance 4/15/2018 FINAL Submission: 5/15/2019	10
Develop plan and Complete Sections in Intervention Proposal Form:		10
C. INTERVENTION IMPLEMENTATION AND TIMELINE FORM		
Complete Implementation and Timeline Form	PRE-Submission: 9/16/2019 Technical Assistance 10/15/2018 FINAL Submission: 11/15/2019	10
FY 19 TOTAL		**30**

FY 20 DELIVERABLES	DEADLINES	POINTS
D. 6- MONTH INTERVENTION REPORTING FORM*		
Complete 6-Month Intervention Reporting Form.	PRE-Submission: 6/15/2020 FINAL Submission: 7/30/2020	15
E. 12-MONTH INTERVENTION REPORTING FORM*		
Complete 12-Month Intervention Reporting Form.	PRE-Submission: 12/15/2020 FINAL Submission: 2/15/2021	15
FY 20 TOTAL		**30**
FY 21 DELIVERABLES	**DEADLINES**	**POINTS**
F. 18-MONTH INTERVENTION REPORTING FORM		
Complete 18-Month Intervention Reporting Form. (Stainability plan)	PRE-Submission: 6/15/2021 FINAL Submission: 7/15/2021	30
FY 21 TOTAL		**30**

*See the 2020 QIPD Workplan for submission dates

FY18-FY20 FOCUS BONUS

LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B

OVERVIEW

In June 2017, the Michigan Medicaid Managed Care Plan Division (MCPD) identified Low Birth Weight (LBW) as a target outcome associated with the FY 2018 Pay for Performance (P4P) Initiative for the Medicaid Health Plans (MHPs). The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated by MCPD in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population.

The project will utilize the 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Live Births Weighing Less Than 2,500 Grams (LBW-CH) measure. Michigan has been reporting the LBW-CH measure rate since 2014 and ranged from 8.50% to 10.40% over the past 3 years. The Center for Disease Control and Prevention (CDC) National Center for Health Statistics indicates that the percent of babies born low birthweight was 8.07% in 2015. (Source: https://www.cdc.gov/nchs/fastats/birthweight.htm; https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf)

The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by prosperity region and race/ethnicity. This breakdown of the date will identify health disparities and methods to improve quality care and services to pregnant women and infants.

The LBW P4P project also aligns with Michigan's 2016-2019 Infant Mortality Reduction Plan (IMRP) and statewide Regional Perinatal Quality Collaborative efforts. The 2016-2019 IMRP contains 2 goals related to health equity and the elimination of racial and ethnic disparities. In Michigan, deaths due to prematurity (birth prior to 37 weeks gestation) and/or low birth weight (less than five and a half pounds) are the leading causes of infant mortality. (Source: 2016-2019 IMRP)

PROJECT GOAL

MCPD is launching this multi-year statewide Pay for Performance (P4P) initiative to align MDHHS efforts to promote health equity in maternity care and infant care. For FY 2018, the goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate.

The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.

PURPOSE

The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach:

- Preconception
- Timeliness of prenatal care
- Post-partum care

The Low-Birth Weight project will follow a similar format to the FY15-17 ED Utilization Focus Bonus. MDHHS has provided the MHPs with the following guidance:

1. Literature Review: MHPs will conduct a literature review with respect to Low-Birth Weight. The Michigan State University Institute for Health Policy (MSU IHP) has provided an extensive list of articles related to the topic. MHPs must analyze at least three scholarly articles with one of their sources from the MSU IHP literature review.
2. Member Data: MSU IHP performed a thorough data analysis of LBW rates by race/ethnicity and prosperity region. MHPs are expected to provide a barrier and gap analysis report to identify the data collection method used to their intervention. The report must incorporate the findings provided by MSU IHP.
3. Partnership Scan: MHPs must gather input from members who receive prenatal care and identify barriers and gaps based on the regional data analysis. MHPs are required to identify and partner with external organizations in specific regions. The partnerships must include evidence-based models of care that incorporate clinical care, home visiting, Community Health Workers (CHWs)/peer support, and community collaboration.
4. Intervention Considerations: MHPs will be required to create and describe potential interventions to improve LBW rates. The intervention considerations will include the identification risk factors by race/ethnicity and prosperity region as well as establishing and maintaining partnerships to support the intervention.

SUBMISSION AND SCORING

There are four components of the LBW project in which the health plans must complete: Baseline Analysis; Intervention Proposal; Intervention Implementation and Timeline Form; and Intervention Reporting.

- **Baseline Analysis:**
  The purpose of the Baseline Analysis activity is to develop an in-depth understanding of low birth weight that includes a review of literature; data collection and analysis.
- **Intervention Proposal:**
  The purpose of the Intervention Proposal activity is to develop interventions that target low birth weight from findings of the baseline analysis. The Intervention Proposal must be approved by MDHHS to proceed with the Intervention Implementation and Reporting.
- **Intervention Reporting:**
  The purpose of the Intervention Report is to report the results of the intervention and ongoing assessments at six and twelve month intervals.

Requesting guidance from the QIPD Section is highly encouraged. MDHHS offers the MHPs the opportunity to submit a Review submission at least a month prior to the Final due date. The review submission allows MDHHS to review and provide feedback (if necessary) to the Plans before submission date.

Questions or comments about the FY18-FY20 Low Birth Weight Focus Bonus submissions and scoring should be directed to the MDHHS Quality Analyst (QA), Ashley Edwards at: EdwardsA11@michigan.gov.

FY 18 DELIVERABLES	DEADLINES	POINTS
A. BASELINE ANALYSIS FORM		
Complete Sections I. and II. of the Baseline Analysis Reporting Form: 1. Literature Review Report	PRE-Submission: 8/15/2018 FINAL-Submission: 9/28/2018	2
2. Low Birth Weight Member and Provider Data - Table A LBW Member Data - Low Birth Weight Member Demographics - Table B LBW Provider Data - Medicaid Health Plan (MHP) Population Health Contact		3
FY 18 TOTAL		**5**
FY 19 DELIVERABLES	**DEADLINES**	**POINTS**
Logic Model	*PRE-Submission:* *7/12/2019* *FINAL Submission:* *8/30/2019*	*N/A*
FY 20 DELIVERABLES	**DEADLINES**	**POINTS**
B. INTERVENTION PROPOSAL FORM		
Complete Sections in the Intervention Proposal Form:	PRE-Submission: 10/18/2019 Technical Assistance 9/26/2019 FINAL Submission: 11/21/2019	10
Develop plan and Complete Sections in Intervention Proposal Form:		10
C. INTERVENTION IMPLEMENTATION AND TIMELINE FORM*		
Complete Implementation and Timeline Form	➢ See 2020 QIPD Workplan	10
D. 6- MONTH INTERVENTION REPORTING FORM*		
Complete 6-Month Intervention Reporting Form.	➢ See 2020 QIPD Workplan	10
FY 20 TOTAL		**40**
FY 21 DELIVERABLES	**DEADLINES**	**POINTS**
E. 12-MONTH INTERVENTION REPORTING FORM*		
Complete 12-Month Intervention Reporting Form.	➢ See 2020 QIPD Workplan	20
FY 21 TOTAL		**20**

*See the 2020 QIPD Workplan for submission dates

APPENDIX 5c

FY18-FY20 FOCUS BONUS

EMERGENCY DEPARTMENT (ED) UTILIZATION

BACKGROUND

Public Act (PA) 107 of 2013 105(d)(13) requires that Emergency Department (ED) utilization be included in the performance bonus. PA 107 called for a symposium to examine the issues of ED utilization and provide best practice recommendations for reduction. To align with the symposium report released in December 2014, ED utilization reduction efforts were initiated as the focus bonus for FY16 and FY17. The purpose of the FY16 and FY17 ED utilization Focus Bonus was designed for Medicaid health plans to create a process to develop an in-depth understanding of ED utilization relative to a health plan's population; and to develop and implement interventions addressing complex issues that impact beneficiary utilization.

To comply with PA 107, MDHHS will continue with the efforts to address the needs of high/super utilizers in Michigan. For the next three fiscal years, the ED utilization Focus Bonus will concentrate on one of three topics to lower inappropriate ED utilization in the Michigan Medicaid Managed Care population. These topics include: A) integration with behavioral health, B) substance use disorder treatment, or C) dental services.

There are a number of approaches Medicaid health plans can use to reduce inappropriate use of ED utilization. Care coordination and community partnerships are a couple of strategies to increase access to comprehensive services, to address social determinants of health (SDoH), and to improve health outcomes. Effective examples of care coordination and collaboration include:

- Creation or continuation of existing contracts with agencies to implement Community Health Worker (CHW) programs
- Collaboration with community-based organizations such as public health departments, mental health services, substance abuse treatment centers, etc.
- Partner with dental organizations/practices
- Work with transportation agencies

IMPORTANT*:* The Intervention Proposal for the ED utilization Focus Bonus will require a community collaboration component.

PURPOSE

Emergency Department (ED) utilization provides a snapshot about quality and access issues faced by Michigan Medicaid beneficiaries and their surrounding community. Health Plans will explore and develop innovative initiatives to improve the effectiveness and performance of ED utilization. Interventions should focus on the reduction and/or elimination of ED visits related to A) behavioral health, or B) substance use disorder treatment, or C) dental problems. They should also emphasize the clinical and non-clinical aspects of a member's socio-logical system. Goals may include improvement in health outcomes; enhanced coordination of services and partnering with non-traditional healthcare providers; and increased cost-effectiveness with a major effort to lower inappropriate ED Utilization in the Michigan Medicaid Managed Care population. To assist health plans with their ED Utilization Focus Bonus, the following forms have been designed to serve as a guide to the health plans:

- **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 incorporate a community collaboration and 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 four forms the health plans must complete: 1) Baseline Analysis; 2) Intervention Proposal; 3) Intervention Implementation and Timeline Form; and 4) Intervention Reporting.

There are two submission dates for the Baseline Analysis and the Intervention Proposal forms, as these submissions must be approved by MDHHS. The first/review submission date allows the Quality Improvement and Program Development (QIPD) Staff to review and provide feedback to the Plans, allowing revisions (if needed) before submitting for final MDHHS approved submission date.

Requesting guidance from the QIPD Section is highly encouraged relative to ED utilization Focus Bonus.

Questions or comments about the Fy17-FY20 ED utilization Focus Bonus submissions and scoring should be directed to the MDHHS Quality Analyst (QA), Rachel Copeland at: copelandr1@michigan.gov.

FY18-FY20 FOCUS BONUS:
EMERGENCY DEPARTMENT (ED) UTILIZATION TIMELINE

FY 18 DELIVERABLES	DEADLINES	POINTS
A. BASELINE ANALYSIS FORM		
Complete Sections I. and II. of the Baseline Analysis Reporting Form: 1. Literature Review Report (pg. 1) 2. Initial ED Visit Analysis Report (pg. 2)	PRE-Submission: 1/15/2018 Final Submission: 2/15/2018	2 2
Develop plan and complete Sections III. and IV. Of the Baseline Analysis Reporting Form: 1. Plan for Gathering Input from Members (pg. 3) 2. Plan for Analyzing Barriers and Gaps (pg. 4)		3 3
Subtotal		**10**
B. INTERVENTION PROPOSAL FORM		
Complete Sections I. and II. of the Intervention Proposal Form: 1. Barrier and Gap Analysis Report (pg. 1) 2. Partnership Scan Report (pg. 3)	PRE-Submission: 5/31/18 Technical Assistance 7/10/2018 Final Submission: 7/31/2018	4 4
Develop plan and Complete Sections III. and IV. of the Intervention Proposal Form: 1. Plan for ED Utilization Interventions (pg. 5) 2. Plan for Ongoing Assessment (pg. 7)		6 6
Subtotal		**20**
FY 18 TOTAL		**30**
FY 19 DELIVERABLES	**DEADLINES**	**POINTS**
C. INTERVENTION IMPLEMENTATION AND TIMELINE FORM		
Complete Implementation and Timeline Form	10/15/2018	**10**
D. 6- MONTH INTERVENTION REPORTING FORM		
Complete 6-Month Intervention Reporting Form.	PRE-Submission: 5/15/2019 Final Submission: 6/15/2019	**20**
FY 19 TOTAL		**30**
FY 20 DELIVERABLES	**DEADLINES**	**POINTS**
E. 12-MONTH INTERVENTION REPORTING FORM		
Complete 12-Month Intervention Reporting Form.	PRE-Submission: 11/15/2019 Final Submission: 12/15/2019	**10**
F. 18-MONTH INTERVENTION REPORTING FORM*		
Complete 18-Month Intervention Reporting Form.	PRE-Submission: 6/15/2020 Final Submission: 7/15/2020	**20**
FY 20 TOTAL		**30**

*See the 2020 QIPD Workplan for submission dates

APPENDIX 5d

2020 Pay for Performance – Healthy Michigan Plan Cost-Sharing and Value-based Services

***PURPOSE*:**

Cost-Sharing and Value-based Services are key components of the Healthy Michigan Plan (HMP). Medicaid Health Plans (MHPs) will create and/or maintain systems and processes to appropriately implement cost-sharing requirements and to ensure the provision of value-based services.

***CONTEXT*:**

Public Act (PA) 208 of 2018 requires that cost-sharing be included in the performance bonus.

***GOAL*:**

This FY20 Pay for Performance (P4P) incentivizes Medicaid Health Plans to continue to develop and maintain processes related to collection of cost-sharing, incentives and value-based services. There are several domains to be reviewed:

- Performance on Healthy Michigan Plan Measures
- Tracking and confirmation that incentives are applied as required
- Implementing Wellness Programs for HMP members
- Assisting members to meet HMP work requirements

***INSTRUCTIONS*:**

MDHHS offers MHPs the opportunity to submit their documents a month before the final submission date. All documents should be submitted through the FTP Site and the words “Quality Section” should be noted in the comments section to distinguish the files from other submissions.

SCORING:

Total points available for the 2020 P4P HMP Cost-Sharing and Value-based Services: **75 points**.

QUESTIONS:

Questions or comments about the should be directed to MDHHS Quality Analyst, Rachel Copeland at Copelandr1@michigan.gov.

2020 Pay for Performance – Healthy Michigan Plan Cost-Sharing and Value-based Services

The naming convention for 2020 P4P on Healthy Michigan Plan for Cost-Sharing and Value-based Services submissions are listed below:

Performance Area	Naming Convention	Submission Date	Points Allocated
Wellness Programs	<MHP Acronym>2020 Wellness Prog_PRE <MHP Acronym>2020 Wellness Prog_FINAL	Final Submission: **January 31, 2020**	8 Points
Work Requirements	<MHP Acronym>2020 HMP Work Comm_Coll_PRE <MHP Acronym>2020 HMP Work Comm_Coll_FINAL <MHP Acronym>2020 HMP Work CHW_PRE <MHP Acronym>2020 HMP Work CHW_FINAL	• Community Collaboration Final Submission: March 15, 2020 • CHW Final Submission: September 30, 2020	25 points
HMP Measures	No MHP submission is required.	No MHP submission is required.	20 Points
HMP Dental Measures	No MHP submission is required	No MHP submission is required.	22 points

2020 Pay for Performance – Healthy Michigan Plan
Cost-Sharing and Value-based Services

PERFORMANCE AREA	CRITERIA/DELIVERABLES			DUE DATE AND POINTS
	GOAL	MINIMUM STANDARD	SOURCE	
Work Requirements	Community Collaboration – To support their members to meet the HMP work requirements, Medicaid health plans (MHPs) must collaborate with community organizations that address the socio- economic barriers that impact individuals' ability to participate in the workforce. MHPs must submit a community-led initiative in each service area region for MDHHS approval. MCPD will provide a template for MHPs to complete for submission.	All criteria will be achieved, and program will receive MDHHS approval.	MHP	15 Points
	Community Health Workers – Health plans must submit a report/template to describe their utilization of CHWs to identify and target members in need of community resources to address social determinants of health, including work requirements. MCPD will provide a template for MHPs to complete for submission.	All criteria will be achieved for CHW report.	MHP	10 Points
Wellness Programs	Health plans must have at least two wellness and/or population health management programs to meet the requirements of the Healthy Behaviors Incentive Program for MDHHS approval. This submission can include previously approved and/or newly submitted programs.	All criteria will be achieved, and program will receive MDHHS approval.	MHP	January 31, 2020 **4 points**
	Health plans must submit at least one wellness program record received each quarter (Oct 2018-Sept 2020) on the 5944 Healthy Behaviors file.	At least one wellness program record received each quarter (Oct 2018-Sept 2020) on the 5944.	MDHHS Data Warehouse	October 2020 **4 points**

Healthy Michigan Plan (HMP) Measures	MDHHS will monitor or report results for the HMP measures below: **a. Adult Generic Drug Utilization** Enrollees who had a generic prescription filled during the measurement period	**80%**	MDHHS Data Warehouse	July 2020 **12 points** *(4 points for each measure)*
	b. Completion of Annual Health Risk Assessment (HRA) Measure The percentage of Healthy Michigan Plan beneficiaries enrolled in a Health Plan who had a Health Risk Assessment (HRA) completed within the last twelve (12) months.	**12%**	MDHHS Data Warehouse	
	c. 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 The minimum standard for this measure will be applied to an aggregate score of all PMR quarters.	**50%**	MDHHS Data Warehouse	
	d. Consistently Fail to Pay (CFP) Status HMP members who: 1. Transitioned from non-CFP status to CFP status during the last quarter of the measurement period. -or- 2. Transitioned from CFP status to non- CFP status during the last quarter of the measurement period. A standard is set for each FPL (≤ 100% and > 100%) for both members transitioning into CFP status and for members transitioning out of CFP status, producing a total of four (4) standards for this measure.	FPL >100%: ≤30% FPL ≤100%: ≤7% Members transitioning from non-CFP Status into CFP status (Reverse Measure) FPL >100%: ≥ 2% FPL ≤100%: ≥ 2% Members transitioning out of CFP Status into non-CFP status	MDHHS Data Warehouse	July 2020 **8 points** *(2 points for each rate)*

2020 Pay for Performance – Healthy Michigan Plan
Cost-Sharing and Value-based Services

Healthy Michigan Plan (HMP) Dental Measures	MDHHS will monitor or report results for the HMP Dental measures below: a. **Diagnostic Dental Services** HMP members who received at least one diagnostic dental service within the measurement period.	• **<50th percentile = 0 pts** • 50th percentile 30% = 4 pts • 75th percentile 36% = 6 pts • 90th percentile 40% = 8 pts • **>90th percentile >40% = 11 pts**	MDHHS Data Warehouse	*January 2020* *April 2020* *July 2020* *October 2020* (Aggregate score of all PMR quarters *will be calculated)*
	b. **Preventive Dental Services** HMP members who received at least one preventive dental service within the measurement period.	• **<50th percentile = 0 pts** • 50th percentile 17% = 4 pts • 75th percentile 24% = 6 pts • 90th percentile 27% = 8 pts • **>90th percentile >27 = 11pts**	MDHHS Data Warehouse	

APPENDIX 5e

Performance Bonus
Integration of Behavioral Health and Physical Health Services FY 20

Category	Description	Criteria/Deliverables
1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk, who have been identified as receiving services from both entities. MDHHS will quarterly select beneficiaries at random and review their care plan in CC360.
Important Note about FY 20 Behavioral/Physical Health Measurement Period **FY 20 Performance Bonus measurement periods for all Behavioral/Physical Health measures will change to calendar year (January 1, 2019 to December 31, 2019) to align with typical MDHHS performance measurement periods associated with the Performance Bonus. This will result in a 6 month period (January 1—June 30, 2019) being measured and incentivized for FUH performance in both FY 19 and FY 20.**		
2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (65 points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	Plans will meet set standards for follow-up within 30 Days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. See MDHHS measure specification for query, eligible population and additional details. Measurement period will be January 1-December 31, 2019. The points will be awarded based on MHP/PIHP combination performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity.
3. Plan All-cause Readmission (PCR)	For members 18 years of age or older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	This measure will be **informational only.** Measurement period will be January 1-December 31, 2019. Plans will be expected to review and validate data with the goal of setting benchmarks for FY21
4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	Members 13 years and older with an Emergency Department (ED) visit for alcohol	This measure will be **informational only.** Measurement period will be January 1-December 31, 2019. Plans will be expected to review and validate data with the goal of setting benchmarks for FY21.

APPENDIX 5f

Alternative Payment Model (APM)

Contract Appendix – Pay for Performance Bonus Program FY 20

Medicaid Health Plans (MHPs) have been working towards increasing the use of APMs, with the goal of improving quality of care while better managing costs. Each MHP has submitted an APM strategic plan that detailed how they plan to increase their use of APMs through FY20. In addition, MHPs have submitted cost and quality data related to their APMs. The APM deliverables related to the MDHHS Performance Bonus for the FY20 Program will include an APM progress report, cost data analysis as well as quality data reporting. These components were part of the previous year's APM Bonus Program. For FY20 MDHHS has doubled the capital related to APMs, as the Care Management and Care Coordination measure and benchmark were added to this year's program.

Domain	Deliverables	Due Date	Points
APM Progress Report	1) Comparative Analysis of CY19 APM Targets – How did you perform compared to your strategic plan projections for increasing the use of APMs? i) Compare historical data ii) Compare to goals iii) Compare to contracts 2) Impact of APMs on Cost/Quality – What was the impact of the APM on patient care and outcomes, and overall medical expenses of the plan? 3) Challenges /opportunities – What was your experience? 4) Plans for moving forward, beyond CY19 – What changes, if any, will you make to your APM strategy and implementation plan? Please include State-Preferred PCMH Model strategy and implementation update. <u>This may be due to your comparative analysis of APM targets, your own experience, and any further information provided by MCPD that impacts your APM plan.</u>	Pre-Submission: May 15, 2020 Final Submission: July 17, 2020	10 5 page limit
APM Data Collection Tool	1) Submit CY 19 APM Data Collection Tool 2) Data Validation Review (10-page limit) a. How did you verify that you correctly followed directions? i. Is reporting different this year vs. previous year ii. Comparing historic reporting processes iii. Documenting data collecting/reporting process iv. Updates based on MCPD guidance	Pre-Submission: May 15, 2020 Final Submission: July 17, 2020	10

Alternative Payment Model (APM)

Contract Appendix – Pay for Performance Bonus Program FY 20

Domain	Deliverables	Due Date	Points
Regional Measure Performance	1) Report overall MHP Performance by Region for CY19 a. Use table from implementation plan with added column for actual rate of performance as calculated by the Plan 2) Provider Report Samples a. Share a sample of how providers get information on their own performance. Should include progress towards quality benchmarks, and budgets targets if applicable (Categories 3/4). 3) Provide narrative of impact of APM strategy on regional measure performance and potential changes the MHP may make to the APM strategy based on these outcomes. What was your experience with Regional measures linked to APMs compared to the same measures not linked to APMs for certain providers/regions? (5 page limit)	Pre-Submission: August 28, 2020 Final Submission: October 30, 2020	10
Plan-Specific Measure Performance	1) Report overall MHP Performance for CY19 a. Use table from implementation plan with added column for actual rate of performance as calculated by the Plan 2) Provider Report Samples a. Share a sample of how providers get information on their own performance. Should include progress towards quality benchmarks and budget targets if applicable (Cat 3/4). 3) Provide narrative of impact of APM strategy on plan specific measure performance and potential changes the MHP may make to the APM strategy based on these outcomes. What was your experience with plan-specific measures linked to APMs compared to the same measures not linked to APMs for certain providers? (5 page limit)	Pre-Submission: August 28, 2020 Final Submission: October 30, 2020	10

Alternative Payment Model (APM)

Contract Appendix – Pay for Performance Bonus Program FY 20

Domain	Deliverables	Due Date	Points
Overall Performance on Other Measures Included in APMs	1) Report overall MHP Performance a. Use table from implementation plan with added column for actual rate of performance as calculated by the Plan 2) Provider Report Samples a. Share a sample of how providers get information on their own performance. Should include progress towards quality benchmarks and budget targets if applicable (Cat 3/4). 3) Provide narrative of impact of APM strategy on plan specific measure performance and potential changes the MHP may make to the APM strategy based on these outcomes. What was your experience with these measures linked to APMs compared to the same measures not linked to APMs?	Pre-Submission: August 28, 2020 Final Submission: October 30, 2020	10
Care Management & Care Coordination	Measure Specification includes 12 Care Management and Care Coordination codes. Measurement year is January 1, 2020 – September 30, 2020), no continuous enrollment criteria will be applied, and Health Plan Attribution is applied at time of service. Member months will be used to calculate the ratio benchmarks. Historical data was used to determine benchmarks. Measure 1: 38 Codes Submitted per 1,000 MM Measure 2: Health Plan Specific: # of Codes submitted per 1,000 MM Measure 3: 1.7% of Beneficiaries received a CM/CC service Measure 4: Health Plan Specific: Percentage of Beneficiaries Served Each Measure is worth 12.5 points.	December 20, 2020	50
		TOTAL	**100**

APPENDIX 5g

ENCOUNTER QUALITY INITIATIVE (EQI) REQUIREMENTS FOR MEDICAID HEALTH PLANS

Fiscal Year 2020 P4P Program

Medicaid Health Plans (MHPs) will be incentivized to perform relative to the criteria and due dates below with regard to MDHHS Encounter Quality Initiative activities:

Deliverable/Criteria	Due Date	Points
1. MHP attendance and participation at 75% of encounter quality monthly phone meetings (9/12 months)	Monthly as scheduled	6
2. Timely submission of EQI reports and reconciliation template according to the EQI schedule	In accordance with the Encounter Quality Initiative Schedule	3
3. Completion of the EQI reconciliation template	In accordance with the Encounter Quality Initiative Schedule	6
	Total	**15**

The current Encounter Quality Initiative schedule addresses date requirements up to May 2020. An updated schedule detailing the remainder of FY 20 will be provided to MHPs.

APPENDIX 6
Recommendations for Preventive Pediatric Health Care by the American Academy of Pediatrics at http://brightfutures.aap.org

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

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 a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations 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 the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

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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	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]	●[9]	———	——➤	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★——●	——●	●[10]——➤	★——●	——●	●——➤	★——●	——●	●——➤	★——●	——●	●——➤
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]								●			●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	———	——➤																											
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	★——●	——➤	★	★	★	★	★	★	★——●	——●	●——➤		
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	★——●	——➤		★	★	★	★
Cervical Dysplasia[31]																																●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★															
Fluoride Varnish[34]							★——●	——●	——●	——●	——●	——●	——●	——●	——●	——➤																
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★						
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

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 Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns 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 newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "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. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "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).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.cesar-boston.org/CRAFFT/Index.php.
15. 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.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ——● ——➤ = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. 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-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. 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 "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).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/55/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "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).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. 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*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 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.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. 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-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "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*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 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."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

APPENDIX 7

MEDICAID MENTAL HEALTH AND 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 are required to 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): 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.
- 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, including individuals that have been considered to be seriously mentally ill longer than 12 months ago but require residual supports to manage their SMI 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 outpatient mental health services; this service may or may not require authorization from the MHP.	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.	The MHP is responsible for payment for ED visits. 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. 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, including those who have previously been considered to have a serious mental illness but have not had treatment within the past 12 months, and who require only ongoing Medication management services 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.	The MHP is responsible for payment of ED visits. 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	PIHP	PIHP	N/A	Refer to the document "Medicaid	If necessary, ED staff may refer the patient	The PIHP is responsible for

Disorder				Mental Health Substance Use Disorder Inpatient Medical Acute Detoxification" for information regarding acute care hospital inpatient medical detoxification.	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 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.	payment.
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. <u>Exchange of Information</u>

   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

(iv) 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 Purchasin
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)

Due Date: January 15

MHP:

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

Category I Health Benefit Manager	**Notify MDHHS at least 30 calendar 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 at least 21 calendar days prior to 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 at least 30 calendar days prior to effective date** **Type B Notify MDHHS at least 21 calendar days prior to 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 October 1, 2016 through September 30, 2017.

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. Rates will be distributed under a separate cover and are incorporated herein by reference.

APPENDIX 14

Appendix 14 Medicaid Health Plan Provider Network Standards					
	non-rural		Rural		ALL
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Ratios Provider : Enrollee
Primary Care Providers (adult)	30 minutes	30 miles	40 minutes	40 miles	1:500
Primary Care Providers (pediatric)	30 minutes	30 miles	40 minutes	40 miles	1:500
OB/GYN	30 minutes	30 miles	40 minutes	40 miles	
Cardiology	30 minutes	30 miles	40 minutes	40 miles	
Outpatient Behavioral Health*	30 minutes	30 miles	75 minutes	75 miles	
Hospital	30 minutes	30 miles	60 minutes	60 miles	
Pharmacy	25 minutes	25 miles	30 minutes	30 miles	
General Dentistry	30 minutes	30 miles	40 minutes	40 miles	Kalkaska [1:692] Missaukee [1: 873] Schoolcraft [1:806] All other counties [1:650
To be counted in the PCP or general dentistry ratio calculation, a provider must be enrolled in Medicaid, and must be at least full-time (minimum of 20 hours per week per practice location)					

Provider Network Exceptions

Exceptions, if any, to these time and distance standards will be at the sole discretion of MDHHS and only considered based on the number of Providers practicing in the identified specialty participating in the MHP service area and in consideration of the following circumstances:

a) For adult and pediatric PCPs, OB/GYN, Specialists,, and Behavioral Health providers:
   i) When the availability of providers in the service area are limited in number and type, especially in areas designated as Health Professional Shortage Areas.
   ii) The geographic characteristic of the service area is rural in nature.
   iii) Service delivery pattern of the service area.
b) For hospitals:
   i) The availability of a hospital(s) located within the service area.
   ii) The Contractor's ability to contract with hospital(s) located within the Contractor's service area.
   iii) The participation of a hospital(s) located within the Contractor's service area, with MDHHS' Hospital Access Agreement.

* Consistent with Covered Services and MHP responsibilities as defined in this Contract, including, but not limited to Appendix 7.

APPENDIX 15

Appointment and Timely Access to Care Standard

Type of Care / Appointment	Length of Time
Emergency Services	Immediately 24 hours/day 7 Days per week
Urgent Care	Within 48 hours
Routine Care	Within 30 Business Days of request
Non-urgent Symptomatic Care	Within 7 Business Days of request
Specialty Care	Within 6 weeks of request
Acute Specialty Care	Within five Business Days of request
Behavioral Health*	Routine care within 10 Business Days of request
	Non-life threatening emergency within six hours of request
	Urgent Care within 48 hours of request

*Behavioral Health is limited to Covered Services

Dental Appointment and Timely Access to Care Standards	
Type of Care	**Length of time**
Emergency Dental Services	Immediately 24 hours/day seven Days per week
Urgent Care	Within 48 hours
Routine Care	Within 21 Business Days of request
Preventive Services	Within six weeks of request
Initial Appointment	Within eight weeks of request

APPENDIX 16

Provider Directory Listing Requirements

Provider Directory Listing Requirements	Requirements by Provider Type					
Directory must give enrollees the option to search Medicaid providers by county	**Health Professionals (PCPs & Specialists)**	**Hospitals**	**Pharmacies**	**Facilities**	**Medical Suppliers and Other Ancillary Health Providers**	**NEMT**
Name	Provider Name	Hospital Name	Pharmacy Name	Facility Name	Health Provider Name	NEMT Provider Name
Address	Yes	Yes	Yes	Yes	Yes	Optional
Telephone Number	Yes	Yes	Yes	Yes	Yes	Yes
Website URL (as applicable	Yes	Yes	Yes	Yes	Yes	Yes
Cultural and linguistic capabilities (including American Sign Language)	Yes	Yes	Yes	Yes		Yes
Whether the provider's office accommodates persons with physical disabilities (including offices and exam rooms)	Yes	Yes	Yes	Yes		Yes
Specialty(s)	Specialty(s)	Hospital Type		Facility Type		N/A
Board Certification	Yes	Hospital Accreditation				N/A
Additional office locations (as applicable)	Yes					N/A
Gender	Yes					N/A
Medical Group affiliation (if applicable)	Yes					N/A
Office hours	Yes					Yes
Whether accepting new patients (include any restrictions)	Yes					N/A
Languages spoken other than English	Yes					Yes
Whether the provider has completed cultural competency training	Yes					N/A

APPENDIX 17

Reserved

APPENDIX 18: COMPLIANCE REVIEW-Program Integrity

Report Reference		Due Date	Period Covered
	Annual Submissions		
Annual Program Integrity Plan for Michigan Medicaid		June 15, 2020	FY 2021: 10/1/20 - 9/30/21 (Next Fiscal Year)
Annual Program Integrity Report for Michigan Medicaid		June 15, 2020	FY 2019: 10/1/18 - 9/30/19 (Previous Fiscal Year)
Quarterly Submissions (previous months reporting)			
	Pre-Submission	**Due Date**	
Quarterly EOB Log	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
Quarterly Data Mining/Algorithm Log	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
Quarterly Tips and Grievances Log	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
Quarterly Overpayments Identified Reporting Form	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
Quarterly Recoveries Reporting Form	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
Quarterly Fraud Referral Log	February 1 May 1	February 15 May 15	October 1st -December 31st January 1st –March 31st

	August 1 November 1	August 15 November 15	April 1st-June 30th July 1st –September 30th
Quarterly Provider Disenrollment Log	February 1 May 1 August 1 November 1	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st –March 31st April 1st-June 30th July 1st –September 30th
	On Request, or while Onsite		
Records		Within three Business Days from the date of the request unless otherwise specified by MDHHS OIG.	
	Ad HOC		
Fraud Referral Form		Within five Business Days from the date of determining a credible allegation of fraud exists.	
Prepayment Review Request Form		Must be approved by MDHHS OIG prior to implementing any prepayment review.	
Excluded Individual Reporting Form		Within 20 Business Days of the date of discovery/disclosure.	
Network Provider Adverse Action Reporting Form		Within 20 Business Days of any adverse actions taken by the Contractor.	