This STANDARD CONTRACT ("Contract") is agreed to between the State of Michigan (the "State") and ("Contractor"). This Contract is effective April 1, 2018 ("Effective Date"), and unless terminated, expires on September 30, 2021. The Transitional Implementation Period will be the time period between the Contract Effective Date and the Services Begin Date on October 1, 2018. Contractor must commence performance of all Services, without interruption, on October 1, 2018.

This Contract may be renewed for up to five additional one-year period(s). Renewal is at the sole discretion of the State and will automatically extend the Term of this Contract. The State will document its exercise of renewal options via Contract Change Notice.

The parties agree as follows:

1. Duties of Contractor. Contractor must perform the services and provide the deliverables described in Schedule 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 Schedule 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.

<table>
<thead>
<tr>
<th>If to State:</th>
<th>If to Contractor:</th>
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</thead>
</table>

3. Contract Administrator. The Contract Administrator for each party is the only person authorized to modify any terms of this Contract, and approve and execute any change under this Contract (each a “Contract Administrator”):
4. **Program Manager.** The Program Manager for each party will monitor and coordinate the day-to-day activities of the Contract (each a “Program Manager”):

<table>
<thead>
<tr>
<th>State:</th>
<th>Contractor:</th>
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</table>

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 Schedule A) if, in the opinion of the State, it will ensure performance of the Contract.

6. **Insurance Requirements.** 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.

<table>
<thead>
<tr>
<th>Required Limits</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial General Liability Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Minimal Limits:</td>
<td>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.</td>
</tr>
<tr>
<td>$1,000,000 Each Occurrence Limit</td>
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<tr>
<td>$1,000,000 Personal &amp; Advertising Injury Limit</td>
<td></td>
</tr>
<tr>
<td>$2,000,000 General Aggregate Limit</td>
<td></td>
</tr>
<tr>
<td>$2,000,000 Products/Completed Operations</td>
<td></td>
</tr>
<tr>
<td><strong>Umbrella or Excess Liability Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Minimal Limits:</td>
<td>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.</td>
</tr>
<tr>
<td>$5,000,000 General Aggregate</td>
<td></td>
</tr>
<tr>
<td><strong>Automobile Liability Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Minimal Limits:</td>
<td>Contractor must have their policy include Hired and Non-Owned Automobile coverage.</td>
</tr>
<tr>
<td>If a motor vehicle is used in relation to the Contractor’s performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.</td>
<td></td>
</tr>
<tr>
<td><strong>Workers’ Compensation Insurance</strong></td>
<td>Waiver of subrogation, except where waiver is prohibited by law.</td>
</tr>
<tr>
<td>Minimal Limits:</td>
<td></td>
</tr>
<tr>
<td>Coverage according to applicable laws governing work activities.</td>
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<tr>
<td><strong>Employers Liability Insurance</strong></td>
<td></td>
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<tr>
<td>Minimal Limits:</td>
<td></td>
</tr>
<tr>
<td>$500,000 Each Accident</td>
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<tr>
<td>$500,000 Each Employee by Disease</td>
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<tr>
<td>$500,000 Aggregate Disease.</td>
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</tr>
<tr>
<td><strong>Privacy and Security Liability (Cyber Liability) Insurance</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Privacy and Security Liability (Cyber Liability) Insurance

Minimal Limits:
- $20,000,000 Each Occurrence
- $20,000,000 Annual Aggregate

Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.

### Crime (Fidelity) Insurance

**Minimal Limits:**
- $5,000,000 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 as their interests may appear.

### Professional Liability (Errors and Omissions) Insurance

**Minimal Limits:**
- $10,000,000 Each Occurrence
- $10,000,000 Annual Aggregate

### Category I: Type A – Administrative Subcontractors that make payment decisions are required to pay for and provide the type and amount of insurance listed below:

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial General Liability Insurance</strong></td>
<td>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 2010 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.</td>
</tr>
<tr>
<td><strong>Automobile Liability Insurance</strong></td>
<td>Contractor must have their policy include Hired and Non-Owned Automobile coverage.</td>
</tr>
<tr>
<td><strong>Workers’ Compensation Insurance</strong></td>
<td>Waiver of subrogation, except where waiver is prohibited by law.</td>
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<tr>
<td><strong>Employers Liability Insurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Privacy and Security Liability (Cyber Liability) Insurance</strong></td>
<td></td>
</tr>
</tbody>
</table>
Minimal Limits:
$1,000,000 Each Occurrence  
$1,000,000 Annual Aggregate

Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.

Crime (Fidelity) 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 as their interests may appear.

Professional Liability (Errors and Omissions) Insurance

Minimal Limits:
$1,000,000 Each Occurrence  
$3,000,000 Annual Aggregate

Category I: Type B – Administrative Subcontractors that perform administrative functions such as credentialing, utilization management, or case-management are required to pay for and provide the type and amount of insurance listed below:

<table>
<thead>
<tr>
<th>Required Limits</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial General Liability Insurance</strong></td>
<td>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 04. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.</td>
</tr>
<tr>
<td><strong>Automobile Liability Insurance</strong></td>
<td>Contractor must have their policy include Hired and Non-Owned Automobile coverage.</td>
</tr>
<tr>
<td><strong>Workers’ Compensation Insurance</strong></td>
<td>Waiver of subrogation, except where waiver is prohibited by law.</td>
</tr>
<tr>
<td><strong>Employers Liability Insurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Privacy and Security Liability (Cyber Liability) Insurance</strong></td>
<td></td>
</tr>
</tbody>
</table>
Minimal Limits:
$1,000,000 Each Occurrence
$1,000,000 Annual Aggregate

Contractor must have their policy 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:
$1,000,000 Each Occurrence
$3,000,000 Annual Aggregate

Category II – Providers (or Network Providers) are required to pay for and provide the type and amount of insurance specified below:

<table>
<thead>
<tr>
<th>Required Limits</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Malpractice Liability Insurance</strong></td>
<td></td>
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<tr>
<td>Minimal Limits:</td>
<td></td>
</tr>
<tr>
<td>$200,000 Each Occurrence</td>
<td></td>
</tr>
<tr>
<td>$600,000 Annual Aggregate</td>
<td></td>
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<tr>
<td>Deductible Maximum:</td>
<td></td>
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<tr>
<td>$5,000 Each Occurrence</td>
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</tbody>
</table>

If any of the required policies provide claims-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 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 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 this Section; (c) notify the Contract Administrator within five 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).

7. Reserved.

8. Reserved.

9. **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.

Contractor hereby acknowledges that the State is and will be the sole and exclusive owner of all right, title, and interest in the Contract Activities and all associated intellectual property rights, if any. Such Contract Activities are works made for hire as defined in Section 101 of the Copyright Act of 1976. To the extent any Contract Activities and related intellectual property do not qualify as works made for hire under the Copyright Act, Contractor will, and hereby does, immediately on its creation, assign, transfer and otherwise convey to the State, irrevocably and in perpetuity, throughout the universe, all right, title and interest in and to the Contract Activities, including all intellectual property rights therein.
10. **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 at least 90 calendar days 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. Contractor remains responsible for the completion of the Contract Activities, compliance with the terms of this Contract, and the acts and omissions of the subcontractor. The State, in its sole discretion, may require the replacement of any subcontractor.

Under this Contract, there are two classifications of Subcontractors:

**Category I: Administrative Subcontractors**

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

- Type A Administrative Subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or another function involving payment decisions.
- Type B Administrative Subcontractors perform administrative functions such as credentialing, utilization management, or case-management.
- Type C Administrative Subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical decisions. This type of Administrative Subcontractor includes but is not limited to identification care production and mailing services.

**Category II: Provider (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 Enrollee.

The Contractor must notify the State of a change of any Administrative Subcontractor at least 21 calendar days prior to the proposed delegation. The State reserves the right to approve or reject the Contractor's proposed use of any Administrative Subcontractor.

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

12. **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.

13. **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 and provide all necessary documentation and signatures.

14. **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.

15. **Ordering.** Contractor is not authorized to begin performance until receipt of authorization as identified in Schedule A.
16. **Acceptance.** Contract Activities are subject to inspection and testing by the State within 30 calendar days of the State’s receipt of them (“State Review Period”), unless otherwise provided in Schedule A. If the Contract Activities are not fully accepted by the State, the State will notify Contractor by the end of the State Review Period that either: (a) the Contract Activities are accepted, but noted deficiencies must be corrected; or (b) the Contract Activities are rejected. If the State finds material deficiencies, it may: (i) reject the Contract Activities without performing any further inspections; (ii) demand performance at no additional cost; or (iii) terminate this Contract in accordance with Section 23, Termination for Cause.

Within 10 business days from the date of Contractor’s receipt of notification of acceptance with deficiencies or rejection of any Contract Activities, Contractor must cure, at no additional cost, the deficiency and deliver unequivocally acceptable Contract Activities to the State. If acceptance with deficiencies or rejection of the Contract Activities impacts the content or delivery of other non-completed Contract Activities, the parties’ respective Program Managers must determine an agreed to number of days for re-submission that minimizes the overall impact to the Contract. However, nothing herein affects, alters, or relieves Contractor of its obligations to correct deficiencies in accordance with the time response standards set forth in this Contract.

If Contractor is unable or refuses to correct the deficiency within the time response standards set forth in this Contract, the State may cancel the order in whole or in part. The State, or a third party identified by the State, may perform the Contract Activities and recover the difference between the cost to cure and the Contract price plus an additional 10% administrative fee.

17. **Reserved.**

18. **Reserved.**

19. **Reserved.**

20. **Terms of Payment.** Invoices must conform to the requirements communicated from time-to-time by the State. All undisputed amounts are payable within 45 days of the State’s receipt. Contractor may only charge for Contract Activities performed as specified in Schedule A. Invoices must include an itemized statement of all charges. 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.

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](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.

21. **Liquidated Damages.** Liquidated damages, if applicable, will be assessed as described in Schedule A.

22. **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.

23. **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 24, 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.

24. **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 25, 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.

25. **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 365 calendar days), 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.

26. **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.

27. **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.

28. **Limitation of Liability and Disclaimer of Damages.** **IN NO EVENT WILL THE STATE’S AGGREGATE LIABILITY TO CONTRACTOR UNDER THIS CONTRACT, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS CONTRACT, EXCEED THE MAXIMUM AMOUNT OF FEES PAYABLE UNDER THIS CONTRACT.** The State is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

29. **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.

30. **Reserved.**

31. **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 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.
32. 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 Confidential Information is not feasible, such party must destroy the Confidential Information and must certify the same in writing within five calendar days from the date of termination to the other party. However, the State’s legal ability to destroy Contractor data may be restricted by its retention and disposal schedule, in which case Contractor’s Confidential Information will be destroyed after the retention period expires.

33. **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.
34. Reserved.

35. Reserved.

36. **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.

37. **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 will be accurate and complete, and contains no false statements or omits any fact that would make the information misleading, and that (i) Contractor is neither currently engaged in nor will engage in the boycott of a person based in or doing business with a strategic partner as described in 22 USC 8601 to 8606. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 23, Termination for Cause.

38. **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.

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

40. Reserved.

41. Reserved.

42. **Nondiscrimination.** Under the Elliott-Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., Contractor and its subcontractors agree not to discriminate against an employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex, height, weight, marital status, or mental or physical disability. Breach of this covenant is a material breach of this Contract.

43. **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.
44. **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.

45. **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.

46. **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.

47. **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.

48. **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.

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

50. **Entire Agreement and Order of Precedence.** This Contract, which includes Schedule A – Statement of Work, and expressly incorporated schedules and exhibits, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, this Contract, excluding its schedules, exhibits, and Schedule A – Statement of Work; (b) second, Schedule A – Statement of Work as of the Effective Date; and (c) third, schedules expressly incorporated into this Contract as of the Effective Date. NO TERMS ON CONTRACTOR’S INVOICES, ORDERING DOCUMENTS, WEBSITE, BROWSE-WRAP, SHRINK-WRAP, CLICK-WRAP, CLICK-THROUGH OR OTHER NON-NEGOTIATED TERMS AND CONDITIONS PROVIDED WITH ANY OF THE CONTRACT ACTIVITIES WILL CONSTITUTE A PART OR AMENDMENT OF THIS CONTRACT OR IS BINDING ON THE STATE FOR ANY PURPOSE. ALL SUCH OTHER TERMS AND CONDITIONS HAVE NO FORCE AND EFFECT AND ARE DEEMED REJECTED BY THE STATE, EVEN IF ACCESS TO OR USE OF THE CONTRACT ACTIVITIES REQUIRES AFFIRMATIVE ACCEPTANCE OF SUCH TERMS AND CONDITIONS.

51. **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.

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

53. **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.

54. **Contract Modification.** This Contract may not be amended except by signed agreement between the parties (a “Contract Change Notice”). Notwithstanding the foregoing, no subsequent Statement of Work or Contract
Change Notice executed after the Effective Date will be construed to amend this Contract unless it specifically states its intent to do so and cites the section or sections amended.
STATE OF MICHIGAN

Contract No. 171-18000000451
Healthy Kids Dental Program

SCHEDULE A
STATEMENT OF WORK
CONTRACT ACTIVITIES

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This schedule identifies the anticipated requirements of the Contract. The term "Contractor" in this document refers to:

PROJECT REQUEST
This is a Contract for the administration of the Healthy Kids Dental Program.

BACKGROUND
The Michigan Department of Health and Human Services (MDHHS) is seeking to further improve the quality and access of oral health services for its younger population through its managed care Dental Service delivery model, Healthy Kids Dental (HKD).

The HKD model functions similarly to commercial dental plans. The program serves approximately 955,000 individuals statewide. Most Enrollees are medically underserved, of lower socioeconomic status, minority racial and ethnic groups and include varied Persons with Special Health Care Needs populations. Serving this population requires a thoughtful, experienced and deliberate approach in service delivery.

Under this Contract, the Contractor must administer all Dental Plan benefits as described in the Statement of Work. MDHHS will be responsible for determining Beneficiary eligibility and subsequent Dental Plan enrollment.

The Contractor must have the capacity to innovate and collaborate with other stakeholders including Michigan Health Plans. Collaborative and innovative efforts will be used to:

1. Address and overcome dental obstacles for the enrolled HKD population.
2. Increase coordination of physical and oral health for HKD Enrollees.

Oral Health in Michigan
In April 2015, the Center for Health Workforce Studies (CHWS), School of Public Health, University at Albany, State University of New York, published the Oral Health in Michigan Report. In its report, CHWS concluded that Michigan has made significant strides in expanding dental care access and improved oral health outcomes for its residents through Michigan's innovation and collaborative efforts. The report also concluded Michigan has a number of remaining challenges in its continuing efforts to improve oral health. These challenges include:

- Limited access to oral health services in some geographic areas
- Need to improve Population Health literacy and reduce dental anxiety
- State's dental workforce is not distributed evenly with the population
- Need to increase private dentist participation in public programs

In 2016, MDHHS, in Collaboration with the Michigan Oral Health Coalition and input of various stakeholders, developed the 2020 Michigan State Oral Health Plan (MSOHP). This plan was developed in an effort to achieve improved oral health outcomes by 2020. The three plan goals are:

- Enhance professional integration between providers across the lifespan
- Increase knowledge and awareness of the importance of oral health to overall health
- Increase access to oral health care among underserved and/or hard to reach populations

Similar to the CHWS report, the MSOHP recognized the progress Michigan has made in oral health. The MSOHP


The MSOHP also identified the low utilization of preventive Dental Services by children and adolescents. According to MSOHP research, in 2012, over half (52%) of Michigan's children age one to five years did not have a preventive dental care visit during the past year. Additionally, 12% of children six to 11 years and 11% of adolescents 12 to 17 years did not have preventive dental care. When income is considered, the disparity is greater. At a national level, children and adolescents living below 100% federal poverty level are more likely to have untreated caries and less likely to have one dental sealant (MDHHS, 2015). Michigan children and adolescents face a similar circumstance.

Though Michigan has made great strides in the HKD program, it is continuously looking to improve oral health outcomes by leveraging its previous program knowledge, engaging community partners and collaborating with stakeholders to find solutions. Contractor must recognize 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).

The program is designed to offer greater access and choice for Enrollees, while allowing administration to operate similarly to commercial Dental Plans. This approach is used both for program flexibility and improved dentist participation.

Contract Goals
The HKD program is a key component of Michigan's comprehensive oral health plan. Specific goals include:

1. Leveraging the HKD model to promote good oral health practices among the HKD population that result in:
   - increased utilization of preventive Dental Services
   - increased oral health education that emphasizes the importance of good oral health and practices
   - decreased dental anxiety
2. Promoting a patient-centered approach that recognizes the importance of dental care in overall health care and promoting professional integration and coordination of care across provider types.
3. Increasing the number of dental providers participating in the HKD program.
4. Increasing access to oral health care.
5. Designing and implementing best practices for Dental Service delivery in dental care health shortage areas with limited dental providers.
6. Collaborating with community organizations and stakeholders resulting in partnerships that leverage existing dental programs (i.e. school based, dental clinics etc.).
7. Increasing education and Dental Service usage among Enrollees who are pregnant and Children with Special Needs.

SCOPE
Contractor(s) will be responsible for total benefit administration including, but not limited to: claims and encounter data, provider network capacity and maintenance, education and outreach, credentialing, quality assurance, community outreach and collaboration, utilization management, and grievance and appeals. In order to meet MDHHS’ oral health goals, Contractors will be required to work collaboratively with relevant community organizations, stakeholders and MDHHS to devise solutions designed to increase preventive dental service utilization, decrease oral disease and caries and coordinate oral and medical care.

The HKD program offers comprehensive dental coverage with some coverage limitations. The program generally covers:

- Emergency Dental Services
- Diagnostic Services
- Preventive Services
- Sealants
- Restorative Services
- Limited Adjunctive Services
- Endodontic Services
- Limited crown coverage
- Prosthodontics
- Removable Prosthodontics
- Oral Surgery Services
- Additional Medically Necessary Dental Services

1.0 General Requirements
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 dental records, report formats, information systems, liability policies, provider network information and other details specific to performing the contracted services must be available to MDHHS and CMS upon request.

I. Service Area
   A. Service Area
      1. Regional Service Area
         Contractor must provide contracted services statewide (all Michigan regions), as listed in Appendix A. Contractor must meet all network requirements outlined in this Contract for the region(s) the Contractor serves.

II. Medicaid Eligibility
   A. Medicaid Eligibility Determination
      1. The HKD benefit program provides dental coverage for individuals 0 through 20 years of age and is funded under both the Title XIX (Medicaid) and Title XXI (Children’s Health Insurance Program (CHIP) of the Social Security Act. MDHHS has the sole authority to determine whether individuals meet statutory eligibility requirements and will determine eligibility for enrollment in the HKD benefit program.
      2. MDHHS will determine Beneficiary eligibility annually.
      3. Contractor must require network providers to verify Enrollee eligibility at time of service delivery.
   B. Loss of Medicaid Eligibility During Treatment
      1. Contractor must cover services for Enrollees that lose Medicaid or CHIP eligibility while enrolled in the Contractor’s dental plan during the course of treatment that require appointments beyond the last day of eligibility, provided the services are completed within 60 days from the date of eligibility loss. The capitation payment made to the Contractor will cover the completion of these services.

III. Covered Services
   A. Generally Covered Services
      1. Contractor must have available and provide, at a minimum, the appropriate medically necessary covered services defined as services related to the following:
         a. The prevention, diagnosis and treatment of dental disease
         b. The ability to assess and deliver age-appropriate dental services
         c. The ability to restore and maintain dental function
         d. The promotion of good oral health practices to beneficiaries
      2. The Contractor must conform to professionally accepted standards of care and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an Enrollee.
      3. Contractor must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If new Medicaid covered dental services are added, expanded, eliminated, or otherwise changed, Contractor must implement the changes consistent with State direction and the terms of this Contract.
      4. Contractor must ensure all reporting requirements, quality assurance, and compliance activities required by MDHHS of the Contractor apply equally to all Subcontractors used for the provision of covered services.
   B. Dental Services Covered Under this Contract
      1. Contractor must provide or arrange for the provision of the full range of covered dental services as described in this Contract and outlined below and in Appendix B, Covered Code of Dental Terminology (CDT) Codes.
      2. The Contractor is required to cover, at a minimum, all CDT codes covered by MDHHS Medicaid at a rate not lower than the established Medicaid reimbursement rate. The HKD program utilizes the CDT as the nationally accepted code set. All code definitions set by the CDT apply to Medicaid policy. It is the responsibility of the Contractor to comply with the most current MDHHS policy and code additions and communicate this information to its network providers.
      3. Contractor may choose to provide services over and above those specified. Covered dental services provided to Enrollees under this Contract include, but are not limited to, the following:
         a. Emergency dental services
         b. Diagnostic services
         c. Preventive services
         e. Restorative services
         f. Limited adjunctive services
         g. Endodontic services
         h. Limited crown coverage
         i. Prosthodontics
         j. Removable prosthodontics
k. Oral surgery services
l. All medically necessary services

4. Medically Necessary 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 State statutes, regulations, the State Plan, Medicaid Provider Manual and other State policy and procedures. The Contractor must:

a. Provide all early periodic screening diagnostic and treatment services as required in this Contract.
b. Provide for the prevention, diagnosis, and treatment of an Enrollee's oral disease, condition, and/or disorder that results in oral health impairments and/or disability.
c. Provide for the ability for an Enrollee to achieve age-appropriate growth and development.
d. Provide for the ability for an Enrollee to attain, maintain or regain oral functional capacity.
e. Provide for the opportunity for an Enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice as it relates to oral health.

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

a. The Contractor must provide EPSDT services as medically necessary in accordance with 42 USC Sec. 1396d(r)(3)(5), 42 CFR part 441, Subpart B, and MSA 16-01 (Appendix M) whether or not such services are covered under the State Plan and without regard to established limits.
b. 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.
c. The Contractor must provide Enrollees with all covered services in accordance with the Michigan Dental Periodicity Schedule (Appendix L) as adopted from the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.
d. Contractor must not have overly burdensome prior authorization requirements for referrals for diagnostic and/or treatment services determined necessary by the Enrollee's dental provider. This includes, but is not limited to:
   i. Must make any prior authorization requirements available to its providers
   ii. Must establish appropriate clinical basis for prior authorization criteria
   iii. Must respond to prior authorization requests in accordance with 42 CFR 438.210(d), not later than 72 hours for urgent requests and 14 days for routine dental service requests

e. Contractor must provide all treatment and diagnostic services as determined necessary by the referring dental provider to correct or ameliorate any conditions found by the referring dental provider.
f. Contractor must provide outreach to Enrollees due or overdue for well-child (preventive)/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. The State will inform HKD beneficiaries of their EPSDT benefits.

6. Oral Health Promotion, Outreach and Education

1. Contractor must provide outreach and education to Enrollees that promotes good oral health practices to prevent dental disease in accordance with requirements outlined in section XI. Population Health Management of this Contract.
2. Contractor must not charge an Enrollee a fee for participating in health promotion and education programs for covered services described in this Contract.
3. Contractor must include official HKD branding on all outreach and educational materials.

7. Emergency Services

a. Contractor must develop, and make available to Enrollees, a dental emergency protocol including directing Enrollees with life threatening emergencies to appropriate emergency services.
b. Contractor must provide Enrollees a list of after-hours emergency dental providers.
c. Contractor must make available a toll-free dental emergency contact line 24 hours per day seven days per week. The Contractor's dental emergency contact line must respond to each Enrollee emergency request within one hour of request. Unacceptable contact line responses include, but is not limited to:
   i. The contact line is only answered during office hours;
   ii. The contact line is answered after-hours by a recording that tells Enrollees to leave a message;
   iii. The contact line is answered after-hours by a recording that directs Enrollees to go to an
Emergency Room for any services needed; and
iv. Returning after-hours calls outside of four working hours.
d. Contractor must ensure emergency dental services are available 24 hours per day and seven
days per week.
e. Contractor must be responsible for payment of all out-of-plan or out-of-area dental emergency
services and oral examinations provided by a dental emergency provider.
f. Contractor must cover emergency dental services regardless of whether the emergency provider
notified the Contractor of the Enrollee’s Dental Emergency Services.
g. Contractor must provide dental services needed to evaluate and treat an emergency dental
condition found to exist using a prudent layperson standard. Contractor acknowledges that
emergency dental providers offering dental emergency services are required to perform a dental
examination on emergency clients leading to a clinical determination by the examining dentist
that an emergency dental condition does or does not exist. Contractor further acknowledges
that if an emergency dental condition is found to exist, the examining dental Provider must
provide whatever treatment is necessary to treat the condition of the Enrollee.

8. Transportation
a. Contractor must promote the availability of free, non-emergent medical transportation (NEMT)
service benefit for Enrollee healthcare appointments through the local health departments and
State transportation contractor in counties in which it operates, including Wayne, Oakland and
Macomb counties.
b. Contractor must provide Enrollees information on how to access the NEMT services for
appointments for covered services under this Contract including, but not limited to, telephone
numbers, websites, and addresses for such services.
c. Contractor must include NEMT contact information in Enrollee handbooks, promotional and
informational materials.

IV. No Cost Sharing
The Contractor and its network providers and Subcontractors must not require any cost sharing responsibilities
for HKD Enrollees for Covered Services. The Contractor’s network providers are permitted to charge Enrollees
for services delivered beyond covered services if the Enrollee is informed of the additional charges and agrees
to pay for services beyond covered services prior to services being rendered. The Contractor and its network
providers and Subcontractors are prohibited from charging Enrollees for missed appointments. Enrollees may not
be held liable for payments in the event of the Contractor’s insolvency. Enrollees may not be held liable for
payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider.

V. Enrollment and Disenrollment
A. Enrollment Services Contractor
MDHHS contracts with an Enrollment Services Contractor to act as its Agent to contact and educate Medicaid
beneficiaries regarding dental plan choice and assist beneficiaries to enroll, disenroll, and change enrollment
with their dental plan. Contractor must work with the Enrollment Services Contractor as directed by MDHHS.
B. 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 and/or Dental 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 all MDHHS assigned Enrollees without restriction.
C. Initial Enrollment and Automatic Reenrollment
1. Contractor must accept as enrolled all beneficiaries listed on monthly HIPAA-compliant enrollment
files/reports.
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. Auto-assignment of Beneficiaries
1. MDHHS will initially automatically assign beneficiaries to the Contractor. If there are multiple dental plans
assigned to a service area, MDHHS will alternatively assign beneficiaries to a Contractor. Members of
a family unit will be assigned together whenever possible.
2. MDHHS has the sole authority for determining the methodology and criteria used for auto-assignment
of beneficiaries including, but not limited to: historical Enrollee dental utilization, Contractor network
capacity and quality algorithms.
E. 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. In service areas where there are multiple Contractors, MDHHS will provide Enrollees the opportunity to
choose a different Contractor annually based upon each Enrollee’s enrollment effective date.

2. MDHHS will notify Enrollees of their right to disenroll with their current Contractor and reenroll with another Contractor prior to the Enrollee’s open enrollment period.

3. Enrollees will be provided with an opportunity to select any Contractor approved for their county of residence during the annual open enrollment period.

4. Enrollees will be notified that inaction during open enrollment will retain their current Contractor enrollment.

5. 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.

6. New Enrollees or Enrollees who change from one Contractor to another will have 90 days from the enrollment begin date with the Contractor to change Contractors without cause, provided they reside in a service region where there is more than one Contractor.

7. All enrollment changes will be approved and implemented by MDHHS and will be effective the next available calendar month.

F. Enrollment Effective Date

1. When an individual is determined to be Medicaid eligible, enrollment with a Contractor will begin the first day of the month eligibility is received in the State of Michigan’s Community Health Automated Medicaid Processing System (CHAMPS). Only full-month Capitation Payments will be made to the Contractor.

2. 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.

3. When an individual is determined eligible, he or she is eligible for that entire month. Enrollees may be determined eligible retroactively.

4. The Contractor will not be responsible for paying for dental services during a period of retroactive eligibility prior to the date of enrollment with the Contractor.

G. Enrollment Errors by MDHHS

1. If a non-eligible individual 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. 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.

H. Disenrollment from the Contractor

1. Disenrollments are provided to the Contractor daily on the HIPPA-compliant enrollment update files.

2. Enrollees will be disenrolled from the Contractor if the individual:
   a. Loses Medicaid or CHIP eligibility; or
   b. Reaches the age of 21 years
   c. Moves out of Contractor’s service area
   d. Administrative reasons including, but not limited to death and incarceration

I. Disenrollment Discrimination Prohibited

1. Disenrollment provisions apply to all Enrollees equally, regardless of whether enrollment was mandatory or voluntary.

2. Contractors may not request disenrollment because of an Enrollee’s
   a. Change in physical or mental health status
   b. Utilization of medical and/or dental 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 Contractor’s ability to furnish service 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 this 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 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 for the Enrollee’s enrollment will be the effective disenrollment date for the Contractor.
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 (Not Applicable for Contractor’s with statewide Coverage)

1. Contractor must provide all covered services to an Enrollee who moved out of the Contractor’s service area after the effective date of enrollment, until the Enrollee is disenrolled from the Contractor. Contractor may require Enrollees to use network providers and provide transportation and/or authorize out-of-network providers to provide medically necessary services. Contractor may use its utilization management protocols for 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. 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, including, but not limited to: Enrollee death, incarceration or move outside of the Contractor’s service area.

2. Contractor must notify MDHHS of the change in Enrollee’s status and request disenrollment within 15 days of identifying the administrative circumstance.

M. Disenrollment Requests Initiated by the Enrollee

1. Enrollees may request an exception to enrollment in the Contractor’s dental plan if he or she requires significant dental services and is undergoing active treatment with a dental provider who does not participate with the Contractor at the time of enrollment. The Enrollee must submit a medical exception request to MDHHS.

2. The Enrollee may request a “disenrollment for cause” from current Contractor at any time during the enrollment period for the following reasons.
   a. Enrollee’s current Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks and the Enrollee needs related services to be performed at the same time; not all related services are available within the network; and the Enrollee’s dental provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.
   b. Lack of access to dental providers or necessary dental specialty services covered under the Contract. An Enrollee must demonstrate that appropriate care is not available within the Contractor’s provider network or through non-network providers approved by the Contractor.
   c. If Contractor is unable to provide timely access, in accordance with the network adequacy standards of this Contract, to covered services due to too few in-network Indian healthcare providers (IHCP) or out-of-network access to IHCPs.
   d. If Native American Enrollee does not want covered dental services provided through the managed care delivery system.
   e. Enrollee’s demonstrated concern with Contractor’s 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 dental plans, the Enrollee must choose another dental plan in which to enroll.

VI. Network Adequacy

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 children with special 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.

3. Contractor must ensure dental services are available from network providers within the specified access and travel distance and time requirements identified in Appendices C and D from the Enrollee’s home. Exceptions, if any, to these access and 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 Dental Plan service area.

4. Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid Enrollees with physical or mental disabilities.

5. 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.

6. Contractor must attest to, and demonstrate compliance with, contractual network adequacy and timeliness to care requirements on at least an annual basis. As part of compliance review, Contractor must develop, submit and comply with a Network Access Plan as indicated in Appendix E, which describes its network development and network management activities and results. The report must include any findings of provider Subcontractor non-compliance and any corrective action plan and/or measures taken by the Contractor to bring the provider into compliance. The Network Access Plan must demonstrate that the Contractor:

   i. Offers an appropriate range of dental preventive and specialty 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.

7. Contractor must consider anticipated enrollment and expected utilization of services with respect to the specific Medicaid populations.

8. Contractor must ensure contracted Providers offer an appropriate range of preventive and specialty services to meet the needs of all Enrollees, including children with special needs and submit documentation to MDHHS to that effect.

9. Contractor must maintain a general dentist-to-enrollee ratio of at least one full-time unique general dentist per 650 members (minimum of 20 hours per week per practice location), except as otherwise noted in Appendix D. Unique dentist is defined as an unduplicated count of a dentist.

10. Contractor must maintain a network of pediatric dental specialists, to provide care for HKD Enrollees.

11. Contractor must maximize the number of unique dental providers in its network to ensure dental access for Enrollees in accordance with contract appointment and access standards.

12. 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.

13. 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), and diverse cultural and ethnic backgrounds.

14. Contractor must include in its contracted provider network at least one Federally Qualified Health Clinic (FQHC), and one Rural Health Clinic (RHC) if available, in each service area region applicable to the Contractor.

15. Contractor must include a sufficient number of IHCP dental providers in its provider network.

B. Access to Care and Standards for Timeliness of Appointments

1. The Contractor must:

   a. Meet and require its network providers to meet MDHHS standards for timely access to care and services under this Contract, including standards identified in Appendices C and E taking into account the urgency of the need for services.

   b. Make covered services available 24 hours a day, seven days a week, when medically necessary in cases of emergency.

   c. Establish mechanisms to ensure network providers compliance with network access 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.

   d. Require that dental office visits be available during regular and scheduled office hours.

      i. Contractor must ensure that Enrollees have access to after-hours dental services in addition to scheduled daytime hours.

      ii. Contractor must provide Enrollees the hours and locations of service for Contractor’s
iii. 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.

e. Provide access to dental specialists, including specialists in contiguous counties to the Contractor’s service area, if those specialists are more accessible or appropriate for the Enrollee.

f. Ensure Enrollees have access to emergency dental services 24 hours per day, seven days per week.

g. Monitor network providers regularly to determine compliance, and report to MDHHS on:
   i. The amount of time between scheduling an appointment and the date of the office visit including routine appointments, urgent appointments and emergent appointments.
   ii. The length of time Enrollees spend waiting in the provider office.

h. Provide for a second opinion from a qualified dental professional within the network or arrange for the Enrollee to obtain one out-of-network at no cost to the Enrollee.

C. 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 (Appendix E), 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

D. Out-Of-Network Services

1. Contractor must provide adequate and timely access to out-of-network providers and cover medically necessary services for Enrollees in instances when the Contractor’s network is unable to provide those services to the Enrollee in compliance with accessibility and timeliness standards of this Contract. The Contractor must cover such out-of-network services for as long as the Contractor’s provider network is unable to provide adequate and timely access, within MDHHS’ appointment access and time and distance standards of this Contract, for covered medically necessary services for the identified Enrollee(s).

2. Contractor must coordinate with out-of-network providers with respect to payment and follow all applicable MDHHS policies to ensure the Enrollee is not liable for costs greater than would be expected for in-network services including a prohibition on balance billing as required in the Medicaid Provider Manual.

3. Contractor must authorize and reimburse out-of-network providers for medically necessary covered services if such services could not reasonably be obtained by a network provider on a timely basis, within MDHHS’ appointment access and time and distance standards of this Contract, inside or outside the State of Michigan.

4. If the Contractor cannot provide non-emergent covered Services by a network provider within the service authorization and access requirements of this Contract, covered services are considered authorized if the Contractor does not respond to a request for authorization, within 24 hours of the expired time frame of the original service authorization request (III.B. Dental Services Covered Under this Contract.). This provision applies to out-of-network providers inside and outside the State of Michigan.

5. 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 MDHHS has not established a specific rate for the covered service, the Contractor must follow Medicaid policy to determine the correct payment amount.

E. Access and Timeliness Exceptions

MDHHS, at its sole discretion, may grant an exception to its time and distance and access network standards in this Contract in consideration of the following circumstances:

1. For general dentistry and pediatric specialist providers:
   a. When the availability of providers in the service area are limited in number and type, especially in areas designated as health professional shortage areas.
   b. The geographic characteristic of the service area is rural in nature.
   c. Service delivery pattern of the service area.

2. When an exception is granted by MDHHS to a Contractor, the exception is granted for a period of up to one year.
a. The Contractor must develop a plan describing how it will reasonably deliver covered dental services to its Enrollees who will be affected by the exception, included as part of its Network Access Plan.

b. The Contractor must monitor, track and report to MDHHS the delivery of dental services to Enrollees affected by the exception.

F. Provider Directory
   1. Provider Directory
      a. 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 calendar days after the Contractor receives updated provider information.
      b. 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.
         i. 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.
         ii. 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.
         iii. 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.
      c. Contractor’s provider directory must contain, at a minimum, the information listed in Appendix F for network providers.
         i. If applicable, the provider directory must include note of prior authorization or referral requirement for certain providers.
         ii. 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 must be audited at least annually.

G. 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 oral health or be at risk of hospitalization.
   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.

H. 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 Contractor Enrollees. These procedures must meet state requirements and Contractor must coordinated services the Contractor furnishes to the Enrollee
      a. Between settings of care
      b. With the services the Enrollee receives from any other HKD contractor.
      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 HKD contractor 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.

VII. Coordination of Services
A. Federally Qualified Health Centers and Rural Health Clinics
   All references to FQHCs and RHCs in this section (VII.A) refer only to FQHCs and RHCs offering dental services.
   1. Contractor must provide Enrollees with access to dental 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 one RHC, in each service area region applicable to the Contractor.
   3. If a Contractor has an FQHC or RHC in its provider network in the county and allows Enrollees to receive medically necessary services, from the FQHC or RHC, the Contractor has fulfilled its responsibility to provide FQHC and RHC services and does not need to allow Enrollees to access FQHC or RHC services out-of-network.
   4. If a Contractor does not include an FQHC or an RHC in the provider network in the county and an FQHC or RHC exists in the county, the Contractor must allow Enrollees to receive services from the out-of-network FQHC or RHC, as applicable.
   5. FQHC and RHC services must be prior authorized by the Contractor; however, the Contractor may not refuse to authorize medically necessary services if the Contractor does not have an FQHC, or an RHC as applicable, in the network for the service area (county).
   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.
B. Indian Healthcare Providers (IHCP)
   1. Contractor must:
      a. Demonstrate that there are sufficient IHCPs 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 IHCPs, 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 IHCP, 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 make for the services to a participating provider which is not an IHCP; and
         iii. Make payment to all IHCPs 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 IHCP to refer a Native American Enrollee to a network provider.
   2. If timely access, within MDHHS’ appointment and time and distance standards, to covered services cannot be ensured due to few or no IHCPs, Contractor will be considered to have met the requirement in paragraph (1)(a) of this section if Native American Enrollees are permitted by Contractor to access out-of-State IHCPs.
   3. If an IHCP Provider is contracted with the Contractor, Native Americans who are enrolled with the Contractor must be allowed to choose the IHCP Provider as their dental Provider as long as the IHCP dental provider has capacity to provide the services. If the IHCP is not a network provider, 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.).

C. Mobile Dental Facilities and Michigan SEAL! School-Based Program

1. Contractor must provide Enrollees with access to mobile dental services provided by dental facilities listed in the MDHHS Michigan Mobile Dental Facility Permit Directory and the SEAL! School-based dental sealant program.

Michigan mobile dental facilities are listed at: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_6226-339690--,00.html

2. Contractor must not require prior authorization for mobile dental facilities and SEAL! dental services.

3. Contractor may require mobile dental facilities and SEAL! dental services share Enrollee treatment and treatment data for reimbursement.

4. Mobile dental facility and SEAL! dental services are subject to HKD benefit dental service coverage and limitations.

5. Contractor must provide mobile dental facilities and SEAL! dental services with Enrollee benefit coverage information upon request.

6. Contractor must not reimburse the mobile dental facilities and SEAL! dental services no less than the established Medicaid rate for covered dental services.

VIII. Dental Provider Selection

A. Contractor must provide all Enrollees the opportunity to select a general dentist at the time of enrollment.

1. Contractors must not restrict Enrollees’ dental provider choice within its network.

2. Contractors must ensure general dentists can adequately provide all necessary preventive care services.

B. Contractor must have written policies and procedures describing how Enrollees choose general dentists and dental specialists, and how they may change their general dentist and dental specialist.

1. Contractors must provide Enrollees with information on referral and prior authorization requirements for dental specialists.

2. Contractor must not place restrictions on the number of times an Enrollee can change general dentist and/or dental specialist.

C. Contractor must notify all Enrollees who, within the last 12 months, utilized a general dentist and/or dental specialist whose provider Contract will be terminated and assist them in choosing a new general dentist and/or dental specialist prior to the termination of the provider Contract.

IX. 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/her 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 dental records, and request those be amended or corrected
   h. Be furnished dental 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 member 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.
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
C. Member Materials
1. Member Identification Card
   a. Contractor must mail member ID cards to Enrollees via first class mail within 10 business days of being notified of the Enrollee’s enrollment
   b. All other printed information, not including the member ID card, but including member handbook and information regarding accessing services may be mailed separately from the ID card
      i. Member materials stated above 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
   Contractor must obtain MDHHS annual approval of the member handbook prior to dissemination to Enrollees. Contractor must seek approval for any updates or revisions to member handbook after MDHHS annual approval.
   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 children 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 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.

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(f)(2) and any other information required by MDHHS:
   i. Table of contents
   ii. Description of all available Contract services
   iii. Description of no cost sharing to Enrollee
   iv. 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.
   vi. Enrollees’ right to receive FQHC, RHC, IHCP (as applicable) and mobile dental facility, and SEAL! services.
   vii. Enrollees’ right to request information regarding provider incentive arrangements including those that cover referral services that place the dental Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.
   viii. Enrollees’ right to request information on the structure and operation of the Contractor.
   ix. Explanation of any service limitations or exclusions from coverage.
   x. 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.
   xi. 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 (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.
   xii. How Enrollees can contribute towards their own oral health by taking responsibility, including appropriate and inappropriate behavior.
   xiii. How to contact network dental providers.
   xiv. How to contact the Contractor’s Member Services and a description of its function.
   xv. How to access out-of-county and out-of-state services.
   xvi. How to make, change, and cancel appointments with a dental provider.
   xvii. How to obtain oral interpretation services for all languages, not just prevalent languages as defined by the Contract.
   xviii. How to obtain written information in prevalent languages, as defined by the Contract.
   xix. How to obtain written materials in alternative formats for Enrollees with special needs.
   xx. Contractor’s toll-free numbers, including the toll-free number Enrollees use to file a grievance or appeal.
   xxi. Procedures for obtaining benefits, including any requirements for service authorizations and/or specialty care and for other benefits not furnished by the Enrollee’s general dentist.
   xxii. Preventive oral health services for Enrollees (EPSDT).
   xxiii. 24/7 toll-free dental emergency contact line and dental emergency protocol, to the extent
to which, and how, after hours and emergency dental services are provided, including: (1) what constitutes an emergency dental condition and emergency dental services (2) the fact that prior authorization is not required for emergency dental services and (3) The fact that the Enrollee has a right to use any emergency dental provider.

xxiv. 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.

xxv. Restrictions, if any, on the Enrollee’s freedom of choice among network providers.

xxvi. The extent to which, and how, Enrollees may obtain benefits, and supplies from out of network providers.

xxvii. Information on how to report suspected fraud and abuse

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

xxix. How to access continued services upon transition to the Contractor

j. Contractor must give Enrollee notice 30 days prior to intended effective date of any significant changes outlined in Section IX.C.2 Member Handbook.

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

   • Covered benefits
   • Authorization for services
   • Contractor contact information
   • Co-pays

3. Medicaid Certificate of Coverage

a. Contractor must provide Enrollees with a certificate of coverage.

b. Contractor must annually submit the DIFS approved Enrollee certificate of coverage/policy document to MDHHS prior to dissemination to Enrollees. Contractor must submit any updates or revisions to certificate of coverage/policy document after MDHHS annual submission.

c. Enrollee Certificate of coverage/policy document must comply with the State of Michigan insurance code requirements.

4. 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.

c. 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.

d. MDHHS must approve 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 calendar days after an appeal is submitted in writing by the Enrollee. The 30-calendar-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 calendar 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:

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

   2. Within two calendar 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

   3. Resolve the appeal as expeditiously as the Enrollee’s health condition requires and not later than the date the extension expires.
vii. If a grievance or appeal is submitted by a third party, but does not include a signed document authorizing the third party to act as an authorized representative for the Enrollee, the 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.

5. 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 42 CFR §438.02, §438.10 and §438.404. 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.

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. In reviewing appeals for CSHCS Enrollees, the Contractor should utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate or limit pediatric subspecialist provider services.

iii. 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 dental records, and 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, specified in §438.408(b) and (c).

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.

6. 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

7. 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 appeal process has been exhausted.

8. 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-covered 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 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 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 standard service authorization decisions not reached within the timeframes specified in § 438.210(d) on the date that the timeframes expire. (6) For expedited 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) which permits Enrollee 60 calendar days from the date on the adverse benefit determination notice to file an appeal.
      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:
         (iv)i Within 10 days of the Contractor’s mailing the adverse benefit determination notice
         (iv)ii 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 calendar 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.

9. 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. The Contractor may shorten the period of advance notice to five days before the date of action if—(a) the Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee; and (b) the facts have been verified, if possible, through secondary sources.
b. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the 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 days before as required above):
      (ii)i The Contractor has factual information confirming the death of an Enrollee
      (ii)ii The Enrollee submits a signed written statement that:
         • He/she no longer requests the services or;
         • The Enrollee gives information that requires termination or reduction of services and indicates that he/she understands that service termination or reduction will result
   iii. The Enrollee has been admitted into an institution where he/she is ineligible under the plan for further services.
   iv. The Enrollee’s whereabouts are unknown and the post office returns the Contractor’s mail directed to the Enrollee indicating no forwarding address.
   v. The Contractor verified with MDHHS that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth.
   vi. A change in the level of medical care is prescribed by the Enrollee’s Provider.
   vii. The notice involves an adverse benefit determination with regard to preadmission requirements.
   viii. The Contractor may shorten the period of advance notice to five days before the date of action if:
      (viii)i The Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee; and
      (viii)ii The facts have been verified, if possible, through secondary sources.

   c. The notice must include the following components:
   i. The adverse benefit determination the Contractor or Subcontractor 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 including medical necessity 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)

   d. 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

10. State Medicaid Appeal Process
a. The State will 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

11. 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.

12. Grievance and Appeals Records
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 appeals and/or grievances
      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 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.

X. Provider Services
A. Provider Services
   1. Contractor must provide contract and education services for the provider network, including education regarding fraud and abuse.
   2. Contractor must properly maintain dental 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 Network 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 promptly to provider inquiries, questions, and concerns regarding covered services, within timeframes that do not impede the provider’s ability to provide services to Enrollees.
   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 its network providers, the overall goals, objectives and activities of the 2020 Michigan State Oral Health Plan.

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 dental provider if the Enrollees' 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. Require providers to take Enrollees' rights into account when providing services as outlined in 42 CFR 438.100.
9. Ensure Enrollees are not denied a covered service or availability of a facility or provider identified in this Contract.
10. Require providers to not intentionally segregate Enrollees in any way from other persons receiving dental services.
11. Require health professionals to comply with reporting requirements for communicable disease and other health indicators as mandated by State law.

C. Provider Participation
1. Contractors must not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification 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 provider's in-network, the Contractor must give the affected providers written notice of the reason for the decision.
5. Contractor must implement and comply with written policies and procedures for selection and retention of network providers that, at a minimum, meet uniform credentialing and recredentialing policy established by MDHHS in consultation with Contractors that addresses acute, primary, behavioral, and substance use disorders, as appropriate.

D. Provision of Enrollee Grievance, Appeal and Fair Hearing Procedures to Providers
Contractor must provide the following Enrollee grievance, appeal, and state 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 all applicable State and/or federal credentialing/recredentialing requirements of providers within the Contractor’s network, including, but not limited to the requirements specified in this section.
1. Contractor must have written credentialing and recredentialing policies and procedures that do the
following:

a. Ensure quality of care
b. Ensure that all providers rendering services to Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract
c. Verify that the provider is not debarred or suspended by any State or federal agency
d. Require the provider to disclose criminal convictions related to federal health care programs
e. Review the provider’s employees to ensure that these employees are not debarred or suspended by any State or federal agency
f. Require the provider’s employees to disclose criminal convictions related to federal health care programs

2. Recredentialing

a. Contractor must recredential providers at least every three years
b. Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state
c. Contractor must maintain written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor’s medical management standards

3. 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 processes.

4. Enrollee Liability for Payment

Contractor or Contractor’s providers must not hold Enrollees liable 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

XI. Population Health Management

A. Data Aggregation and Analysis

1. General

a. Contractor must have the ability to stratify population health data as indicated in Appendix G (e.g., age, gender, race, ethnicity, etc.).
b. MDHHS will provide the Contractor with population health data on the 834 enrollment file.

2. Data Analysis to Support Population Health Management

a. Contractor must utilize information such as enrollment files (834), claims, encounter data supplemented by utilization management data and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address oral health disparities, improve community collaboration, and enhance care coordination between the Contractor’s provider network and Enrollee physicians and/or specialists.
b. Social determinants to be included in data analysis must include:
   i. Subpopulations experiencing a disparate level of social needs such as housing and federal poverty level.
   ii. Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.
   iii. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.
   iv. Persons with high prevalence chronic conditions, such as diabetes, obesity and cardiovascular disease.
   v. Enrollees in need of complex care management, including high risk Enrollees with dual behavioral health and medical health diagnoses who are high utilizers of services.
   vi. Other populations with unique needs as identified by MDHHS such as foster children or homeless members.

3. Data Reporting

a. Upon MDHHS request, Contractor must report clinical measures and stratify these reports based on Population Health data supplied by MDHHS.
b. Contractor must provide reports for performance projects using population health data.

B. Oral Health Promotion and Disease Prevention

1. Oral Health Promotion and Outreach

a. Contractor must use the 2020 Michigan State Oral Health Plan as part of its guidance in the development of its health promotion and outreach strategies.
b. Prior to implementation, the Contractor must submit to MDHHS, as part of its compliance review, an annual plan on its health promotion and outreach activities, including outreach, referral, and activities related to Enrollee uptake and participation rates.

c. Contractor must take a purposeful and thoughtful approach to its health promotion and outreach activities, assessing Enrollee health risk, life experiences, personal preferences, and culture of the target population.

d. The Contractor must use social determinants of oral health data provided by MDHHS (834 file) to analyze member level data to direct the Contractor’s efforts of targeted interventions, outreach, Enrollee education and health promotion.

e. The Contractor’s health promotion and outreach plan, at a minimum, must identify the target population, service areas, outreach activity schedules and include copies of any materials given to Enrollees. The Plan must also:

   i. Detail how and why the Contractor developed its strategy for its specific activities, target population and service area. Include all supporting utilization data.

   ii. Include all educational materials and efforts performed within the Contract year.

   iii. Include outreach activities each year with no less than one per quarter. Activities must include member related activities and/or events must be conducted in rural area each year. The number of annual outreach activities including rural outreach will be determined by MDHHS.

   iv. Include collaborative outreach, and educational activities with community based organizations. Collaborative activities must be inclusive of Enrollees with limited English proficiency, Children with Special Needs, or those who are pregnant in addition to the general HKD population. The number of collaborative activities conducted per year will be determined by MDHHS.

   v. Include an annual health promotion and outreach report that evaluates the Contractor’s outreach activities conducted in the previous year. This health promotion and outreach report is due to MDHHS as indicated in the compliance review requirements of this Contract.

2. Education and Disease Prevention

a. Contractor must provide its Enrollees with educational materials that promote good oral health practices, including coordination between oral and medical appointments.

b. Contractor must make available to all Enrollees appropriate, culturally responsive educational materials to promote oral health, mitigate the risks for specific conditions, and manage existing conditions. Materials for Enrollee education must include:

   i. 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.

   ii. Literature regarding oral health and wellness promotion programs offered by the Contractor.

   iii. Information regarding the appropriate use of oral health services and prevention of fraud, waste and abuse.

iv. Contractor may provide oral health education in a provider office during an oral health examination provided the health education meet all of the following criteria:

   (iv)i If a member incentive is offered it must be delivered in separate private room.

   (iv)ii No advertisement of the event may be present or distributed in the provider office.

   (iv)iii Only Contractors’ Enrollees may participate.

v. A website, maintained by the Contractor, that includes information on:

   (v)i Preventive oral health strategies

   (v)ii Oral health and wellness promotion programs offered by the Contractor

   (v)iii Updates related to covered services and access to providers

   (v)iv Complete provider directory, and

   (v)v Updated policies and procedures

c. Contractor must target Enrollees and parents of Enrollees in its education efforts to work to decrease dental anxiety by encouraging Enrollee preventive dental utilization and early dental disease intervention.

d. 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.

e. 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 dental offices and facilities, public schools and through mailings.

f. Contractor must implement educational, public relation and social media initiatives to increase Enrollee and network provider awareness of public health programs and other community-based
resources that are available and designed to reduce the impact of social determinants of oral 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/mdhhs/0,5885,7-339-73971_4911_4912_6226-145381--,00.html

C. Oral and Medical Health Coordination
1. Coordination of Care
a. Contractor recognizes the importance of coordinating oral and medical health services in order to effectively address and improve Enrollee overall health status.
b. Contractor must work with MDHHS to develop initiatives to better coordinate services covered by the Contractor and medical staff serving Contractor’s Enrollees.
c. Contractor must collaborate with: primary care providers, community partners, Medicaid health plans, and MDHHS in the treatment of Enrollees collectively served among these parties.
d. Contractor must develop a coordination of care policy as part of the Contractor compliance review, that promotes dental and medical service collaboration among its network providers and submit to MDHHS for approval prior to implementation. As part of its coordination of care policy, the Contractor must require its network providers to participate in coordinated care for Enrollees. Coordinated care includes, but is not limited to, communication and collaboration with Enrollee health care team members such as physicians, case managers and community health workers (CHW) to ensure continuity of care.
e. Contractor must engage in activities that work increase awareness about impact of oral health on Enrollee chronic disease outcomes and improve communication and Collaboration among dental Providers, community partners and medical professionals.
f. Contractor must coordinate care with the school based program SEAL! and mobile dental facilities.
g. Contractor must engage in activities that will educate and build awareness of the benefits of integrated care to its dental Providers.
h. Contractor must build relationships with community partners that will engage in integrated care and promote go oral health practices.
i. Contractor must work collaboratively with community partners to incorporate oral health into the Michigan Community Health Workers curriculum.

XII. 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 children with special needs.
3. Contractor’s Dental 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, the Dental 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 the Population Health Management section of this Contract into the Contractor QAPI program.
b. Identify opportunities to improve the provision of dental 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 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 must be submitted to the MDHHS as part of the annual compliance review. The plan must include, 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
f. Solicits member and network provider input for activities
h. Supports ongoing measurement of clinical and non-clinical effectiveness and member satisfaction
i. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements
j. Evaluates performance using objective quality indicators

7. The written plan must describe how the Contractor will:
   a. Analyze the processes and outcomes of care using currently accepted standards from recognized oral health authorities. The Contractor may include examples of focused review of individual cases, as appropriate.
   b. Analyze data, including social determinants of oral 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 oral health outcomes, including, but not limited to, how they relate to utilization of dental emergency services.
   d. Use measures to analyze the delivery of services and quality of care, over and underutilization of services, oral health disease management strategies, and outcomes of care. Contractor must collect and use data from multiple sources such as 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 current dental 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 an annual 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 dental services to Contractor’s 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 to: HEDIS®, CAHPS, and other MDHHS-defined measures that will aid in the evaluation of quality of care of all populations.

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 dental 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 oral 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, upon request by Enrollees, and annually to MDHHS through the compliance review or upon request.
C. Annual Performance Improvement Projects
1. Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas including any performance improvement projects required by CMS.
2. Each performance improvement project must be designed to achieve significant improvement, sustained over time, in oral health outcomes and Enrollee satisfaction, and must include the following elements:
   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, Caries Risk Assessment (CRA), 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 and children with special needs as defined by MDHHS.
5. Contractor must assess performance for the priority areas identified through 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.

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 I); the performance bonus template is attached to the Contract (Appendix J).

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 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. Utilization Management
1. The utilization management (UM) activities of the Contractor must be integrated with the Contractor’s QAPI program.
2. The major components of Contractor’s UM program must encompass, at a minimum, the following:
   a. Written policies with review decision criteria and procedures that conform to dental industry standards and processes.
   b. A formal utilization review committee directed by the Contractor’s dental 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 must be submitted as part of the annual compliance 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.
4. The policy must also require UM decisions be made by a dental professional who has appropriate clinical expertise regarding the service under review.
5. Contractor must not use UM policies and procedures to avoid providing medically necessary services within the coverages established under the Contract.

6. Contractor's authorization of services policy must establish timeframes for standard and expedited authorization decisions:
   a. These timeframes may not exceed 14 calendar days from date of receipt for standard authorization decisions and 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 dental health, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's dental condition requires and no later than 72 hours after receipt of the request for service.

7. These timeframes may be extended up to 14 additional calendar days if:
   a. The Enrollee or the Provider, requests an extension; or
   b. The Contractor justifies (to the State agency upon request) the need for additional information and explains how the extension is in the Enrollee's interest. The Enrollee must be notified in writing of the plan's intent to extend the timeframe.

8. 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.

H. 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 dental plan performance as determined by MDHHS.

2. MDHHS will determine if the Contractor meets contractual requirements and assess dental plan compliance as outlined in Appendix P and P1. MDHHS reserves the right to conduct a comprehensive compliance review.

I. Contract Remedies and Sanctions
1. MDHHS may utilize a variety of means to assure compliance with Contract requirements. MDHHS will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented.

2. MDHHS may employ Contract remedies and/or sanctions to address any Contractor noncompliance with the Contract. Areas of noncompliance for which MDHHS may impose remedies and sanctions include, but are not limited to, noncompliance with Contract requirements on the following issues:
   a. Marketing practices
   b. Member services
   c. Provision of medically necessary covered services
   d. Enrollment practices, including, but not limited to, discrimination on the basis of oral health status or need for dental 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. Performance standards included in Appendix I of this Contract
   j. Misrepresentation or false information provided to MDHHS, CMS, providers, Enrollees, or potential Enrollees
   k. Certificate of Authority
   l. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

3. MDHHS may utilize intermediate sanctions (as described in 42 CFR 438.700) that may include the following:
   a. Civil monetary penalties in the following specified amounts:
      i. A maximum of $25,000.00 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 $100,000.00 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
      iii. A maximum of $15,000.00 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000.00 overall limit above).
      iv. A maximum of $25,000.00 or double the amount of the excess charges, (whichever is
greater) for charging copayments in excess of the amounts permitted under the Medicaid program. The State will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s).

b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706. If a temporary management sanction is imposed, MDHHS will work concurrently with DIFS.

c. Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.

d. Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the sanction.

e. Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

f. Additional sanctions allowed under State statute or regulation that address areas of noncompliance.

4. If intermediate sanctions or general remedies are not successful, or State determines that immediate termination of the Contract is appropriate, as allowed by Standard Contract Term provisions 23 and 24, the State may terminate the Contract with the Contractor. Contractor may be afforded a hearing before termination of a Contract under this section before termination can occur. The State will notify Enrollees of such a hearing and allow Enrollees to disenroll, without cause, if they choose.

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

XIII. Management Information Systems

A. Management Information System (MIS) Capabilities

1. Contractor must maintain a MIS that supports all the data requirements of this Contract and collects, analyzes, integrates, and reports data as required by 42 CFR 438.242 and MDHHS. The MIS must have the capacity and capability to capture and utilize various data elements required for HKD administration including, but not limited to: utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. The Contractor must have hardware, software, and a network and communications system with the capability and capacity to manage and operate all MIS systems for the following operational and administrative areas:

   a. Collecting data on Enrollee demographics and special population characteristics on services provided to Enrollees as specified by MDHHS through an encounter data system.

   b. Supporting provider payments and data reporting between the Contractor and MDHHS.

   c. Controlling, processing, and paying providers for services rendered to Enrollees.

   d. Collecting service-specific procedures and diagnosis data, collecting price-specific procedures or encounters, and maintaining detailed records of remittances to providers.

   e. Supporting all Contractor operations, including, but not limited to, the following:

      i. Member enrollment, disenrollment, and capitation payments, including the capability of reconciling enrollment and capitation payments received

      ii. Utilization/Quality management

      iii. Case management

      iv. Provider enrollment

      v. Coordination of benefits/third party liability activity

      vi. Claims payment

      vii. Encounter data

      viii. Benefit tracking

      ix. Clinical management

      x. Reporting

      xi. Interface

      xii. Fraud, waste and abuse

      xiii. Grievance and appeal tracking, including the ability to stratify grievance and appeal by population and track separately (e.g. foster children Enrollees)

   f. Contractor must develop, implement and maintain policies and procedures that describe how the Contractor will comply with the requirements of this section.

   g. The Contractor must have a MIS system that can be adapted to changes in business practices/policies within the timeframes negotiated by the Contractor and MDHHS. The Contractor is responsible to cover the cost of such systems modifications over the life of the Contract.

   h. The Contractor must provide MDHHS any updates to the Contractor’s organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of any change. The Contractor must provide MDHHS with official points of contact within its organization for MIS issues, and timely notify MDHHS when these
B. System Functionality
1. The Contractor’s MIS must include key business processing functions and/or features, which must apply across all subsystems as follows:
   a. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
   b. Track medically necessary covered services received by Enrollees through the system, and accurately and fully maintain those medically necessary covered services as HIPAA-compliant encounter transactions;
   c. Transmit or transfer encounter data transactions on electronic media in the HIPAA format to the Contractor designated by MDHHS to receive the encounter Data;
   d. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
   e. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
   f. Employ industry standard dental billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and encounter transactions produced;
   g. Employ the coordination of benefits;
   h. Ability to produce standard explanation of benefits (EOBs);
   i. Pay financial transactions to providers in compliance with federal and State laws, rules and regulations;
   j. Ensure that all financial transactions are auditable according to generally accepted accounting principles;
   k. Ensure that Financial Statistical Reports (FSRs) conform to the Federal Acquisition Regulations (FAR) and the Cost Principles for Expenses with respect to segregating costs that are allowable for inclusion in MDHHS-designed financial reports;
   l. Relate and extract data elements to produce report formats required by MDHHS;
   m. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
   n. Maintain and cross-reference all Enrollee-related most current information;
   o. Include Medicaid or CHIP Program Provider number;
   p. Track utilization of benefits;
   q. Report benefit utilization information to MDHHS;
   r. Track provider NPI number; and
   s. Must use Medicaid beneficiary identification as primary Enrollee identification.
2. The Contractor must assure that systems services are not disrupted or interrupted during the Contract period. The Contractor must ensure the business and systems continuity for the processing of all dental claims and data as required under this Contract.
   a. The Contractor must submit to MDHHS, descriptions of interface and data and process flow for each key business process described in the MIS section of this Contract.
   b. The Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities including:
      i. Disaster Recovery Plan*;
      ii. Business Continuity Plan*;
      iii. Security Plan;
      iv. Joint Interface Plan;
      v. Risk Management Plan; and
   *The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.
   c. Contractor must submit any revisions to the above-mentioned documents for MDHHS review and approval 30 days prior to implementation.
C. Health Insurance Portability and Accountability Act (HIPAA) Compliance
1. Contractor’s MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.
2. Contractor must comply with Accredited Standards Committee (ASC) X12 Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant version.
3. Contractor’s enrollment files transferred to providers and/or subcontractors must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 835 format.
5. Contractor must provide its members with a privacy notice as required by HIPAA, and provide MDHHS
with a copy of its standard privacy notices.

6. Contractors' MIS must adhere to all security and privacy regulations mandated by HIPAA, Health Information Technology for Economic and Clinical Health Act (HITECH), and other applicable federal and State regulations or guidelines.

D. Enrollment Data
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 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., network providers) on or before the first of the month so that Enrollees have access to services.
3. Contractor must reconcile the monthly enrollment files to the monthly payment file within 60 days of the end of each month.
4. Contractor must ensure that MIS support staff have sufficient training and experience to manage files MDHHS sends to the Contractor via the DEG.

E. Encounter Data
1. The Contractor must provide complete encounter data for all medically necessary covered services, including value-added services. Encounter data must follow the format and include the data elements described in the HIPAA-compliant 837D format. MDHHS will specify the method of transmission, the submission schedule, and any other requirements.
2. Contractor must submit encounter data transmissions monthly as specified in Appendix H, and include all encounter data and encounter data adjustments processed by the Contractor. Encounter data quality validation must incorporate assessment standards required by MDHHS.
3. 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.
4. Encounter records must be submitted monthly via electronic media in a HIPAA compliant format as specified by MDHHS.
5. Contractor must populate all fields required by MDHHS including, but not limited to, financial data for all encounters. 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 and risk score calculations. MDHHS will not allow Contractors to submit incomplete encounter data for inclusion into the MDHHS data warehouse and subsequent calculations.
6. 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. The Contractor must participate in regular data quality assessments conducted as a component of ongoing encounter data on-site activity.
7. Contractor must make original records available for inspection by MDHHS for validation purposes upon request. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by MDHHS.
8. For reporting claim encounters submitted on 837D format, Contractor must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by MDHHS. Any exceptions will be considered on a code-by-code basis after MDHHS receives written notice from the Contractor requesting an exception.

F. 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 ensure data received from providers is accurate and complete by:
   a. Verifying the accuracy and timeliness of the data
   b. Screening the data for completeness, logic and consistency
   c. Collecting service information in standardized formats
   d. Identifying and tracking fraud, waste and abuse

G. Electronic Billing Capacity
1. Contractor must offer its providers the option of submitting and receiving claims information through an EDI that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.
2. Contractor must make an Electronic Funds Transfer (EFT) payment process (for direct deposit) available to network providers.
3. Contractor must meet the HIPAA and MDHHS guidelines and requirements for electronic billing capacity and must require its providers to meet the same standard as a condition for payment.
4. Contractor must ensure providers bill the Contractor using the same format and coding instructions required for the Medicaid FFS programs according to Medicaid policy.
5. Contractor must not require providers to complete additional fields on the electronic forms not specified in Medicaid FFS Policy.
6. Contractor may require additional documentation, such as medical records, to justify the level of care provided.
7. Contractor 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.
8. Contractor must maintain the completeness and accuracy of their websites regarding this information.

H. Claims Processing Requirements
1. The Contractor must maintain an automated claims processing system that registers the date a claim is received by the Contractor, the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments.
2. The Contractor claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to MDHHS.
3. The Contractor’s claims system must maintain online and archived files, and keep online automated claims payment history for the most current 36 months.
4. The Contractor must retain financial information and records, including all original claim forms, for the time period in accordance with all federal and State laws.
5. All claims data must be easily sorted and produced in formats as requested by MDHHS.

I. 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% of all clean claims from providers within 30 days of the date of receipt.
   b. Contractor must pay 99% of all clean claims from providers within 90 days of the date of receipt.
   c. Clean claim will mean 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 allowable 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 submitting an annual IRS form 1099, reporting of provider earnings to each provider who receives a payment for services during the calendar year, 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. Contractors must provide an annual summary of the outreach, education, and prevention services as part of the annual report due to MDHHS on March 1 of each year.
2. Provider Preventable Conditions
   a. Contractor is prohibited from making payment to a provider for provider-preventable conditions that are outlined in the Michigan Medicaid 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.
3. Post-Payment Review
   a. Contractor must utilize a post-payment review methodology to assure claims have been paid appropriately.
   b. Contractor must complete post-payment reviews for individuals retroactively disenrolled by MDHHS within 90 days of the date MDHHS notifies the Contractor of the retroactive disenrollment.
   c. Contractor must complete the recoupments from Providers within 90 days of identifying the
claims to be recouped.

d. Contractor must not recoup money from Providers for individuals retroactively disenrolled by MDHHS more than 180 days from the date that MDHHS notified the Contractor of the retroactive disenrollment.

J. 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 (as applicable).
2. Other administrative requests specified by MDHHS.

K. Provider File
1. Provider 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 provider file 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 Provider file must contain all network providers.
5. The Contractor must specifically identify any providers that are IHCPs.
6. 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 as required in this Contract.

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

A. Electronic Health Records (EHR)
MDHHS has established rules and guidelines to advance the adoption and meaningful use of certified EHR technology through the Medicare and Medicaid EHR Incentive Programs authorized by the HITECH.
1. Contractor must promote EHR as part of regular provider communications.
2. Contractor must electronically exchange eligibility and claim information with providers to promote the use of EHR.
3. Contractor must comply with MDHHS performance programs designed to advance provider adoption and meaningful use of certified EHR.

B. Electronic Exchange of Client Level Information
1. Contractor must promote the benefits of electronic exchange of client information in overall treatment of patient.
2. Contractor must have the ability to coordinate Enrollee care among other providers.

C. Michigan Dental Registry (MIDR)
1. Contractor must educate and promote the use and benefits of the MIDR among its network providers.
2. The Contractor is required to register all its network providers in MIDR over the course of the Contract period.

D. Michigan Health Information Network
1. Contractor must become familiar with the Michigan Health Information Network (MiHIN) Shared Services in preparation for future MDHHS EHR and care coordination projects.

XV. 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 Pre-paid Ambulatory Health Plans (PAHPs) are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract.
3. Contractor must maintain financial records for its Medicaid activities separate from other financial records.
C. Accreditation/Certification Requirements
   1. Contractor must have a Certificate of Authority to operate in the State of Michigan in accordance with applicable Michigan Compiled Laws under the authority of the Insurance Director.

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 services, performs billing or coding functions, or is involved in monitoring of Medicaid services provided by the entity.
   5. If the Contractor currently has an employee handbook, the handbook must contain the Contractor’s written policies for employees regarding detection and prevention of fraud, waste and abuse including an explanation of the false claims acts and of the rights of employees to be protected as whistleblowers.

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

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

G. Third Party Resource Requirements
   Third Party Liability (TPL) refers to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, PAHPs, 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. Contractors must seek to identify and recover all sources of third party funds based on industry standards.
   2. Contractor may retain all such collections. If third party resources are available and liability has been established, the Contractor is not required to pay the provider first and then recover money from the third party; however, the Contractor may elect to do so.
   3. Contractor must follow Medicaid Policy regarding TPL. MDHHS TPL policy information can be found in the Medicaid Provider Manual and the State Plan, or available upon request. 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 report third party collections through encounter data submission and in aggregate as required by MDHHS.
   5. 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 will be collected on a quarterly basis starting with January data. Activities performed January through March will be reported by May 15; activities performed April through June reported by August 15; activities performed July through September reported by November 15; and activities performed October through December reported by February 15th.
6. Contractor must collect any payments available from other dental insurers including Medicare and private dental 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.

7. MDHHS will provide the Contractor with a list of known third party resources for its Enrollees. This information will be produced daily and sent to the Contractor on the HIPAA compliant enrollment file.

8. 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.

9. When an Enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any Contractor. Contractor must make the Enrollee whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the Enrollee such as coinsurance and deductible.

H. Marketing

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

1. Contractor must comply with the marketing, branding, incentive, and other relevant guidelines 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 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 dental plans 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 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 MDHHS offices
   b. Provider offices, clinics, including, but not limited to, women, infants and children (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 dental plan name and logo. These decals may be displayed in the provider office to show participation with the dental 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 a dental plan, 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.
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 physical and oral 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 HIPAA; this includes the designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.
2. All Enrollee information, dental 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, but not limited to, dental records and client information.

K. Dental Records
1. Contractor must ensure its providers maintain dental records in a detailed, comprehensive manner that conforms to professional dental practices, permits effective professional dental review, dental audit processes, and facilitates a system for follow-up treatment that permits effective patient care and quality review. Dental records must:
   a. Be signed and dated including entry and submission dates
   b. Be retained for at least 10 years
   c. Include Enrollee identification information
   d. Include Enrollee personal/biographical data
   e. Include provider identification
   f. Be legible
   g. Include past medical history, oral examinations, allergies, immunizations, diagnostic information and emergency care
   h. Identify any current problems
   i. Include as applicable smoking, alcohol and/or substance abuse
   j. Include specialist referrals and results thereof
   k. Include any other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided
2. Contractor must have written policies and procedures for the maintenance of dental records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.
3. Contractor must have written plans for providing training and evaluating Providers' compliance with the recognized dental records standard.
4. Contractor must have written policies and procedures to maintain the confidentiality of all medical records.
5. Contractor must comply with applicable State and federal laws regarding privacy and security of dental records and protected health information.
6. MDHHS and/or CMS must be given prompt access to all Enrollee’s dental records without written approval from an Enrollee before requesting an Enrollee’s dental record.
7. Contractor must require network providers forward Enrollee’s dental records or copies of dental records to the new dental provider, when an Enrollee changes dental providers within 10 business days from receipt of a written request.

XVI. Program Integrity
The MDHHS, Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the PAHPs consistent with this Contract and the requirements at 42 CFR 438.600 through 438.610

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.
   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.
   c. The establishment 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.
   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 should not perform their own training and education.
   e. Effective lines of communication between the Compliance Officer and the Contractor’s employees.
   f. Enforcement of standards through well-publicized disciplinary guidelines.
   g. Establishment and implementation 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.

2. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to MDHHS-OIG. See Section XVI.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 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 XVII.B 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 XVI.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 two weeks 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.

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 XVI.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 establish 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.
Contractor must ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types.

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 XVI.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 XVI.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 XVI.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 XVI.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.

(ii) 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]

(iii) 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 XVI.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 MCPD sFTP. The Contractor must follow the procedures and examples contained within the MDHHS-OIG quarterly submission forms and accompanying guidance document. See Appendix P1 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 XVI.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 XVI.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 XVI.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 XVI 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 (OHHS 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, dental 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 dental records may be kept in an original paper state or preserved on micromedia or electronic format. Dental 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 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. Dentist 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. Records standards;
   n. Payment policies;
   o. Enrollee rights and responsibilities.

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 XVI.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 immediately.

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 form 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.

4. 

1.2 Contractor Readiness Review and Transition

I. Contractor Readiness Review

A. Readiness Review

MDHHS will conduct a readiness review to assess the current capacity of the awarded Contractor(s) to effectively administer and provide the services as defined in this Contract. The Contractor must cooperate with the MDHHS readiness review. The Contractor must have the ability to fully operationalize the Contract requirements on October 1, 2018.

1. Project Initiation

MDHHS will conduct a contract implementation kick-off meeting. All key Contractor project staff must attend in person. MDHHS project staff will provide an orientation to the HKD Program and system requirements. Contractor must also work with MDHHS’ Enrollment Services Contractor for Contract requirements that require coordination of efforts. MDHHS technical staff will provide an overview of the MDHHS Management Information System requirements (emphasizing information exchange) and file requirements including but not limited to:
a. Encounter Data (837D)
b. Enrollment file (834)
c. Capitation payment (820)
d. Provider files
e. Eligibility files (270/271)

After the initial meeting, Contractor must submit to MDHHS a transition plan to include timelines for all systems, operational and member materials readiness for Contract start date.

II. Transition
State will not pay Contractor for activities during the Transitional Implementation Period.

A. Transition
Contractor must work with MDHHS and its Enrollment Services Contractor to transition its operations to include, but not limited to:
1. Benefit plan design loaded, operable and tested.
2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the MDHHS prior to the Contract start date.
3. Eligibility feed formats loaded and tested end to end.
4. Operable and tested toll-free numbers and Contractor websites.
5. Account management, help desk and prior authorization, and quality staff hired and trained.
6. EOB requirements.
7. Network adequacy review.
8. Contractor information system, claims processing system, encounter data and eligibility files are functionally tested and working.
9. Claims history and existing prior authorizations and overrides must be migrated.
10. Development of all required member materials as required in this Contract.
11. Contractor's ability to generate reports as required in this Contract.

B. Implementation/Operations
During this phase, the Contractor and MDHHS will assess readiness of Contractor's information system components to validate the Contractor's ability to meet the MIS requirements as described in this Contract. This will result in the establishment of the operational production environment in which MDHHS provider files can be completed and transferred to MDHHS and all dental claims can be accurately and reliably processed, adjudicated and transferred to MDHHS as encounter data. Contractor must also have the ability to accept and process all MDHHS files including, but not limited, to eligibility and enrollment files. MDHHS may conduct a systems readiness review to validate the Contractor's ability to meet the MIS requirements as described in this Contract.

The Contractor and MDHHS will also assess the Contractor's operational readiness including, but not limited to: staffing, network adequacy, training, policies and procedures, all required member materials, reporting capabilities and quality readiness. Contractor must have an adequate network in place as indicated by the Contractor's total number of executed provider Contracts. Contractor must have converted all Letters of Agreement (LOA) to fully executed Contracts at the time of MDHHS' Readiness Review.

MDHHS will have final approval for the elements of the operational production environment. If for any reason the Contractor does not fully meet any of the readiness requirements, then the Contractor must, upon request by MDHHS, either correct such deficiency or submit to MDHHS a Corrective Action Plan to address such deficiency. If the Contractor is unable to correct or sufficiently address the deficiency, the State may terminate the Contract.

2.0 Acceptance
2.1 Acceptance, Inspection and Testing
The State will use the following criteria to determine acceptance of the Contract Activities: Section 16, of the Standard Contract Terms.

3.0 Staffing, Organizational Structure and Governing Body
3.1 Contractor Representative
The Contractor must appoint a Contractor Representative (can also be a Key Personnel position below), specifically assigned to State of Michigan accounts, that will respond to State inquiries regarding the Contract Activities, answering questions related to ordering and delivery, etc. (the "Contractor Representative"). The Contractor must notify the Contract Administrator at least 30 days before removing or assigning a new Contractor Representative.

3.2 Customer Service Toll-Free Number
Reserved.
3.3. **Work Hours**

The Contractor must provide Contract Activities during the times specified in this Contract.

3.4 **Key Personnel and Responsibilities, Support and Administrative Staff, and Organization Structure**

I. **Key Personnel**

The Contractor must appoint the Key Personnel noted below who will be directly responsible for the day-to-day operations of the Contract ("Key Personnel"). Key Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquiries within 24 hours.

The State has the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor will notify the State of the proposed assignment, introduce the individual to the State’s Program Manager, and provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection. The State may require a 30 day training period for replacement personnel.

Contractor will not remove any Key Personnel from their assigned roles on this Contract without the prior written consent of the State. The Contractor’s removal of Key Personnel without the prior written consent of the State is an unauthorized removal (“Unauthorized Removal”). An Unauthorized Removal does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation, or for cause termination of the Key Personnel’s employment. Any Unauthorized Removal may be considered by the State to be a material breach of this Contract, in respect of which the State may elect to terminate this Contract for cause under Termination for Cause in the Standard Terms or apply Contractor sanctions in accordance with terms outlined in this Contract.

It is further acknowledged that an unauthorized removal will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any unauthorized removal.

A. **Key Personnel**

1. Contractor must employ or contract with sufficient administrative staff to comply with all program standards. At a minimum, Contractor must specifically provide the following Key Personnel positions. Below are the Contractor’s identified personnel for those positions:

   (See section 3.4.I.B for responsibilities)

   a. Executive Director/Chief Executive Officer (CEO) – Laura Czelada
   b. Dental Director – Jeffery Johnston
   c. Quality Improvement and Utilization Director – Erik Stier
   d. Chief Financial Officer (CFO) – Amy Basel
   e. Management Information System Director – Lynn Draschil
   f. Compliance Officer – Kristen Smith
   g. Member Services Director – Toni Roberts
   h. Provider Services Director – Amy Fenson
   i. Grievance and Appeals Coordinator – Jason Snider
   j. Medicaid Liaison – Matt Glover
   k. MIS Liaison – Robert Somers
   l. Security Officer – Andrew Woodard
   m. Privacy Officer – Walter Buzanowski

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. Contractor must inform State in writing within seven days of vacancies or staffing changes for the personnel listed in A.1.a-f of this section.

4. Contractor must inform State in writing within 14 days of vacancies or staffing changes for the personnel listed in A.1.g-m.

5. 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.

B. **Key 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. The Executive Director/CEO must be located in the State of Michigan.
   c. Oversight of budget and accounting systems.
d. Responsible to the governing body for daily operations.

2. Dental Director
   a. Licensed dental professional (DDS or DMD).
   b. Must be located in the state of Michigan.
   c. Responsible for all major clinical program components of the Contractor.
   d. Responsibility to review medical care provided to Enrollees and medical aspects of provider contracts.
   e. Ensure timely medical decisions, including after-hours consultation as needed.
   f. Management of the Contractor's Quality Assessment and Performance Improvement Program.
   g. 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. Licensed dental professional (DDS or DMD).
      ii. Certified quality professional, preferably with dental quality experience (i.e. Certified in Medical Quality (CMQ), Certified Professional in Healthcare Quality (CPHQ).
      iii. Other licensed clinician as approved by MDHHS.
      iv. Other professional possessing appropriate credentials as approved by MDHHS.
   b. Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.

4. Chief Financial Officer
   Full-time administrator responsible for overseeing the budget and accounting systems.

5. Management Information System Director
   Full-time administrator who oversees and maintains the data management system to ensure the MIS is capable of valid data collection and processing, timely and accurate reporting, and correct claims payments.

6. Compliance Officer
   Full-time administrator to oversee the Contractor’s compliance plan and to verify that fraud and abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

7. Member Services Director
   a. Coordination of communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate.
   b. Ensure sufficient member services staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

8. Provider Services Director
   a. Coordination of communications with subcontractors and other providers.
   b. Ensure sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.

9. Grievance/Appeal Coordinator
   Coordination, management, and adjudication of Enrollee and Provider grievances

10. Security Officer
    a. Development and implementation of security policies and procedures outlined in 45 CFR 164.
    b. Designated as the individual to receive complaints pursuant to security breaches in the Contractor’s or State’s policies and procedures.

11. Privacy Officer
    a. Development and implementation of privacy policies and procedures outlined in 45 CFR 164.
    b. Designated as the individual to receive complaints pursuant to breaches of the Contractor’s privacy policies and procedures.

12. Medicaid Liaison:
    Designated as the individual that manages communication between the Contractor’s Medicaid subject matter personnel and MDHHS’ staff.

13. MIS Liaison:
    Designated as the individual that manages communication between the Contractor’s MIS staff and MDHHS’ technical staff.

C. 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 dental care management and must employ or contract with skilled clinicians for dental management activities.

C. 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.

D. 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

E. 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.

F. 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.

3.5. Organizational Chart and Governing Body

I. Organization Chart
The Contractor must provide an overall organizational chart that details staff members, by name and title, and subcontractors to MDHHS upon request.

II. 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 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

3.6 Disclosure of Subcontractors

I. Subcontractor Disclosure Requirements
A. If the Contractor intends to utilize subcontractors, the Contractor must disclose the following per Appendix O – Subcontractor Template.
1. The legal business name; address; telephone number; a description of subcontractor’s organization and the services it will provide; and information concerning Subcontractor’s ability to provide the Contract Activities.
2. The relationship of the subcontractor to the Contractor.
3. Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.
4. A complete description of the Contract Activities that will be performed or provided by the subcontractor.

B. If the Contractor intends to change Subcontractors (see Contract Terms – Section 10 Subcontracting), the Contractor must complete Appendix O – Subcontractor Template and submit to the MDHHS Program
Manager.

II. Subcontractor Classifications
A. Administrative Subcontractors
Administrative Subcontractors are entities that perform administrative functions required by this Contract such as claims payment, delegated credentialing, and card production and mailing services.
1. Administrative subcontractors are classified by function.
   a. Type A administrative subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or other functions involving payment decisions.
   b. Type B-Administrative Subcontractors perform administrative functions 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 necessity decisions. This type of administrative subcontractor includes, but is not limited to, identification card production and mailing services.
2. The Contractor must notify the State (see Contract Terms – Section 10 Subcontracting) of any new administrative subcontractors at least 21 days prior to the effective date of the contract with the administrative subcontractor.
3. MDHHS reserves the right to approve or reject Contractor’s proposed use of an administrative subcontractor.
B. 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 Enrollee

III. 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 the subcontractor section of this Contract in all of its agreements with any subcontractors as specified by type of subcontract.
A. Contractor Full Responsibility
1. 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.
2. Contractor has full responsibility for the successful performance and completion of all Contract Requirements as specified in Schedule A, regardless of whether the Contractor performs the work or subcontracts for the services.
3. If any part of the work is to be subcontracted, the Contractor must provide MDHHS a list of subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted per section 3.6 Disclosure of Subcontractors.
4. 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.
5. 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 Schedule A.
B. State Consent to Delegation
Contractor must not delegate any duties under this Contract to a subcontractor except as specified in section 3.6.
C. Subcontractor Bound to Contract
1. In any subcontracts entered into by Contractor for the performance contractor requirements, Contractor must require the subcontractor, to the extent of the contractor requirements to be performed by the subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State.
2. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State.
3. The management of any subcontractor is the responsibility of Contractor, and Contractor must remain responsible for the performance of its subcontractors to the same extent as if Contractor had not subcontracted such performance.
4. Contractor must make all payments to subcontractors or suppliers of Contractor. Except as otherwise
agreed in writing by the State and Contractor, the State is not obligated to direct payments for the contractor requirements other than to Contractor.

5. The State’s written approval of any subcontractor engaged by Contractor to perform any obligation under this Contract will 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.

4.0 Project Management
Contractor must comply with Contract compliance reviews at the intervals specified by MDHHS.

4.1 Meetings
I. Mandatory Administrative Meetings
   A. Contractor Representatives
      Contractor Representative must attend the following meetings:
      1. Enrollment
      2. QI Directors
      3. Clinical Advisory Committee
      4. CEO
      5. Operations
      6. The State may request other meetings, as it deems appropriate.
   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.

4.2 Reporting
The Contractor must submit, to the MDHHS all reports outlined in this Contract, (also see Appendix H).
I. Data Reporting
   A. Uniform Data and Information
      1. The Contractor must provide MDHHS with uniform data and information as specified by MDHHS to measure the Contractor’s accomplishments in the areas of access to care, utilization, oral health outcomes, Enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates.
      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 4.2 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. Quality Assurance Reports
MDHHS may request reports or improvement plans addressing specific Contract performance issues identified through site visit reviews, EQRs, focus studies, or other monitoring activities conducted by MDHHS.
B. Financial Reports
1. Contractors must meet all financial reporting requirements and provide to MDHHS copies of the financial reports.
2. Contractor must submit annual and quarterly NAIC financial reports in the format required by MDHHS.
3. MDHHS may require monthly financial statements from the Contractor.
4. Contractor must submit data on the basis of which MDHHS:
   a. Certifies the actuarial soundness of capitation rates under § 438.4, 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.
C. HEDIS Submission
1. Contractor must annually submit a Medicaid-product HEDIS report according to the most current NCQA dental 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. Contractor must provide to MDHHS monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by MDHHS.
E. 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.
F. Provider Race/Ethnicity Reporting
Contractor must work with providers and MDHHS to collect and report the race/ethnicity of their contracted providers. Contractor will report the race/ethnicity of contracted providers to MDHHS within the specified timeline.
G. 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. Network access plan as described in Appendix E.
   3. Information on ownership and control described in § 455.104 of as governed by § 438.230.
H. 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.
I. 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, will have access to the State’s data.
C. Acceptable Use of Personally Identifiable Data
   1. Contractor must not possess or assert any lien or other right against the State’s data. Without limiting the
generality of this section, the Contractor must only use personally identifiable information as strictly
necessary to provide the services 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 will 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.

5.0 Ordering
5.1. Authorizing Document
   The appropriate authorizing document for services will be this Contract and MDHHS approval of Contractor
Readiness Review and Transition (see Section 1.2).

6.0 Invoice and Payment
   I. General
      Contracts are full-risk.
   II. Payment Provisions
      A. Fixed Price
         Payment under this Contract will consist of a fixed reimbursement plan with specific monthly payments based
upon a unit price of a Per-Member Per-Month (PMPM) Capitated Rate. 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. Capitation Rates
         1. MDHHS will establish actuarially sound capitation rates developed in accordance with the federal
requirements for actuarial soundness (see Appendix Q). 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.
      C. Regional Rate
         MDHHS will pay Contractor a Per-Member-Per-Month statewide rate. MDHHS at its discretion may adjust
this rate on a regional basis if determined necessary by the State actuary.
      D. Annual Review
         MDHHS will annually review changes in implemented Medicaid Policy to determine the financial impact on
HKD Program. 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 policy changes significantly affect the overall
cost to the HKD Program, MDHHS will consider an adjustment of the fixed price per covered member to maintain the actuarial soundness of the rates.

E. 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. 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.

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

III. Contractor Performance Bonus
A. Performance Bonus
During each Contract year, MDHHS will withhold a percentage 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). The Contractor’s performance will be measured during the rating period under the Contract in which the withhold arrangement is applied.

1. MDHHS will use the first year of the Contract period to establish baseline data for Contractor performance.
2. MDHHS will not withhold a percentage of the approved capitation payment from each Contractor for the first year of the Contract period beginning October 1, 2018 through September 30, 2019.

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.

7.0 Health Insurance Portability and Accountability Act (HIPAA)
7.1 HIPAA Business Associate Agreement Addendum
At the time of Contract execution, the Contractor (“Business Associate”) must sign and return a HIPAA Business Associate Agreement Addendum (Appendix N) to the individual specified in the Standard Contract Terms provision 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.
## APPENDIX A - REGIONAL SERVICE AREAS

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft</td>
</tr>
<tr>
<td>2</td>
<td>Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford</td>
</tr>
<tr>
<td>3</td>
<td>Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon</td>
</tr>
<tr>
<td>4</td>
<td>Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newago, Oceana, Osceola, Ottawa</td>
</tr>
<tr>
<td>5</td>
<td>Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw</td>
</tr>
<tr>
<td>6</td>
<td>Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola</td>
</tr>
<tr>
<td>7</td>
<td>Clinton, Eaton, Ingham</td>
</tr>
<tr>
<td>8</td>
<td>Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren</td>
</tr>
<tr>
<td>9</td>
<td>Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw</td>
</tr>
<tr>
<td>10</td>
<td>Macomb, Oakland, Wayne</td>
</tr>
</tbody>
</table>
All medically necessary services are covered, this is any service necessary to correct or ameliorate defects and physical and mental illnesses and conditions whether or not such services are covered under the State Plan. (See Appendix M-MSA 16-01)

The Contractor is required to cover, at a minimum, all CDT codes covered by MDHHS Medicaid at a rate not lower than the established Medicaid reimbursement rate. Contractors may choose to provide additional services and higher reimbursement rates. The HKD program utilizes the CDT as the nationally accepted code set. All code definitions set by the CDT apply to Medicaid policy. It is the responsibility of the Contractor to comply with the most current MDHHS policy and code additions and communicate this information to its Network Providers.

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic Oral Evaluation</td>
<td>DIAGNOSTIC</td>
</tr>
<tr>
<td>D0140</td>
<td>Limit Oral Eval Problm Focus</td>
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</tr>
<tr>
<td>D0145</td>
<td>Oral Evaluation, Pt &lt; 3yrs</td>
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<tr>
<td>D0150</td>
<td>Comprehensive Oral Evaluation</td>
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<tr>
<td>D0150</td>
<td>Comprehensive Oral Evaluation</td>
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<td>D0190</td>
<td>Screening Of A Patient</td>
<td>PRE-DIAGNOSTIC</td>
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<tr>
<td>D0191</td>
<td>Assessment Of A Patient</td>
<td></td>
</tr>
<tr>
<td>D0210</td>
<td>Intraor Complete Film Series</td>
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<tr>
<td>D0210</td>
<td>Intraor Complete Film Series</td>
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<td>D0220</td>
<td>Intraoral Periapical First</td>
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<td>Intraoral Periapical Ea Add</td>
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<tr>
<td>D0240</td>
<td>Intraoral Occlusal Film</td>
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### Dental Plan Appointment and Timely Access to Care Standards

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<td>Routine Care</td>
<td>Within 21 business days of request</td>
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<td>Preventive Services</td>
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<td>Initial Appointment</td>
<td>Within eight weeks of request</td>
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## APPENDIX D - TIME AND DISTANCE STANDARDS

### Dental Plan Network Time and Distance Standards

| Required Providers | (non-Rural) |  | (Rural) |  | ALL |  |
|--------------------|-------------|-----------------|---------|-----------------|-------------------------------|
|                     | Maximum Time (minutes) | Maximum Distance (miles) | Maximum Time (minutes) | Maximum Distance (miles) | Maximum Ratios ** |
| General Dentistry  | 30 minutes   | 30               | 40 minutes   | 40               | Kalkaska [1:692] |
|                    |              |                  |            |                  | Missaukee [1:873] |
|                    |              |                  |            |                  | Schoolcraft [1:806] |
|                    |              |                  |            |                  | All other counties [1:650] |
| Pediatric Specialist | 90          | 90               | 210         | 210              | if blank, no ratio applies |

**Note**: if blank, no ratio applies

Standards are based upon each county

*Contractor may include Pediatric Specialists that provide comprehensive preventive services in its access calculations of General Dentists

**To be counted in the ratio calculation, a general dentist must be enrolled in Medicaid, and must be at least full-time (minimum of 20 hours per week per practice location). The ratio must reflect the unduplicated number of dentists in each county. If a dentist has multiple office locations and some offices are located in different counties, the Contractor may report the dentist in each county where the dentist practices 20 hours or more per week.
APPENDIX E - NETWORK ACCESS PLAN

Network Access Plan Requirements

1. Contractor must develop and submit an annual Network Access Plan as part of the Contractor compliance review. Contractor may request that MDHHS deem sections of the access plan proprietary, competitive or trade secret and the information must not be made public or subject to the Freedom of Information Act.

2. Contractor must notify MDHHS of any significant change as defined in this Contract to its existing network plan within seven days of the occurrence. The Contractor must submit an updated Network Access Plan to MDHHS within 30 calendar days of occurrence.

3. The Network Access Plan, at a minimum, must contain the following:
   a. The Contractor’s network, including how the availability of telemedicine or telehealth, e-visits, triage lines or screening systems or other technology is used to meet network access standards.
   b. A description of the Contractor’s ongoing efforts to ensure an adequate number of IHCPs, FQHCs and RHCs in its network.
   c. Time and distance tables of network general dentists and pediatric specialists coverage within the Contractor’s service area. Contractor must provide Geo access maps upon MDHHS request. Contractor must also provide its internal analysis of provider ratios of the general dentistry and pediatric dental provider types to support the Contractor’s ability to meet MDHHS’ network adequacy and time and distance standards. The analysis must include a review of the number of unique general dentists in the network and dental access points.
   d. The Contractor’s procedures and time frames for making and authorizing referrals and prior authorizations, if applicable, within and outside its network.
   e. The Contractor’s process for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the oral health needs of the Contractor’s enrolled population for all covered services within MDHHS’ network adequacy and timely access standards.
   f. The factors used by the Contractor to build its provider network, including a description of the network and the criteria used to select providers.
   g. The Contractor’s efforts to address the needs of covered persons, including, but not limited to, those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex, oral health conditions.
   h. The Contractor’s methods for accessing the oral health care needs of the Contractor’s Enrollees and their satisfaction with access to and availability of services.
   i. The Contractor’s process for updating its provider directory.
   j. The Contractor’s process for enabling Enrollees to choose dental providers.
   k. The Contractor’s proposed 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.
   l. The percentage of general dentistry providers accepting new patients specifying those with and without conditions/limitations. Contractors must address, in its plan, how it will work to increase network general dentists accepting new patients without conditions/limitations.
   m. Describe rural service area strategies to maximize oral health network access and availability for Enrollees.
   n. Describe 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 affected Enrollee access to oral health services in areas granted the MDHHS access exception.
      - Report must include: service delivery dates, length of time for requested appointments, location of where Enrollee received service, the distance of office locations from the Enrollee home. Report must exclude patient identifying information.
### APPENDIX F - PROVIDER DIRECTORY REQUIREMENTS

**Provider Directory Listing Requirements**

Directory must give Enrollees the option to search Medicaid Providers by county

---

**Dental Professionals**  
*(General Dentists and Specialists)*

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Website URL (as applicable)</th>
<th>Cultural and linguistic capabilities (including American Sign Language)</th>
<th>Whether the Provider's office accommodates persons with physical disabilities (including offices and exam rooms)</th>
<th>Specialty(ies)</th>
<th>Board Certification</th>
<th>Additional office locations</th>
<th>Gender</th>
<th>Hospital affiliation (if applicable)</th>
<th>Office hours</th>
<th>Whether accepting new patients (include any restrictions)</th>
<th>Languages spoken other than English</th>
<th>Whether the Provider has completed cultural competency training</th>
</tr>
</thead>
</table>

APPENDIX G - STRATIFIED DATA REQUIREMENTS

Dental Plans must have the following data fields for operations

a. Enrollee Name;
b. Enrollee Beneficiary Identification;
c. Enrollee Dental Plan;
d. Dates of Service;
e. Specific service provided by procedure CDT Code;
f. Servicing Provider Number (NPI);
g. Participating Dental Provider Name;
h. Payment status;
i. Billed Charge Amount;
j. Allowed Amount;
k. Payment Amount;
l. Received Date;
m. Payment Date, and
n. Any other data element required by common dental practice, American Dental Association (ADA) and American Association of Pediatric Guidelines, federal or State law.

Dental Plans must have the ability to electronically receive the following data fields in order to stratify member data:

- Age
- Gender
- Race/ethnicity
- Language
- Federal Poverty Level (FPL)
- Area of Residence
- Foster care
- Homeless
- Pregnancy status
- Other

* Dental Plans must have the ability to analyze data collected from the ADA CRA form (Age 0-6) completed and submitted by its Network Providers.
APPENDIX H
Fiscal Year 2019 REPORTING REQUIREMENTS FOR HKD PLANS

These reports are in addition to reports and submissions required by the Annual Compliance Review. All reports must be shared electronically via the MDHHS File Transfer Application. Exceptions are the encounter data and provider file which are submitted electronically via the DEG.

<table>
<thead>
<tr>
<th>Report Reference</th>
<th>Due Date</th>
<th>Period Covered</th>
<th>Instructions/Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Submissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>3/15/19</td>
<td>10/1/18-12/31/18</td>
<td>NAIC</td>
</tr>
<tr>
<td></td>
<td>5/15/19</td>
<td>1/1/19-3/31/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/15/19</td>
<td>4/1/19 – 6/30/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/15/19</td>
<td>7/1/19 – 9/30/19</td>
<td></td>
</tr>
<tr>
<td>Grievance/Appeal</td>
<td>1/30/19</td>
<td>10/1/18-12/31/18</td>
<td>MSA 131 (11/11), Grievance &amp; Appeal Report</td>
</tr>
<tr>
<td></td>
<td>4/30/19</td>
<td>1/1/19-3/31/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/30/19</td>
<td>4/1/19 – 6/30/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10/30/19</td>
<td>7/1/19 – 9/30/19</td>
<td></td>
</tr>
<tr>
<td>Third Party Collection</td>
<td>2/15/19</td>
<td>10/1/18-12/31/18</td>
<td>Report on separate sheet and send with NAIC</td>
</tr>
<tr>
<td></td>
<td>5/15/19</td>
<td>1/1/19-3/31/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/15/19</td>
<td>4/1/19 – 6/30/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/15/19</td>
<td>7/1/19 – 9/30/19</td>
<td></td>
</tr>
<tr>
<td>Monthly Submissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Processing</td>
<td>30 days after</td>
<td>• Data covers previous month</td>
<td>MSA 2009 (E)</td>
</tr>
<tr>
<td></td>
<td>end of the</td>
<td>• i.e., data for 2/18 due by 3/30/18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>month NOT last</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>day of month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounter Data</td>
<td>The 15th of</td>
<td>• Minimum of Monthly</td>
<td>837D Format</td>
</tr>
<tr>
<td></td>
<td>each Month</td>
<td>• Data covers previous month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• i.e., data for 1/18 due by 2/15/19</td>
<td></td>
</tr>
<tr>
<td>Provider Files</td>
<td>Friday before</td>
<td>Submit all Providers contracted with</td>
<td>Provider file layout and file edits distributed by</td>
</tr>
<tr>
<td></td>
<td>the last</td>
<td>the plan on the date of submission</td>
<td>MDHHS</td>
</tr>
<tr>
<td></td>
<td>Saturday of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>each month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caries Risk Assessment (CRA)</td>
<td>At least one</td>
<td>Once the initial appointment is</td>
<td>Layout and file edits distributed by MDHHS</td>
</tr>
<tr>
<td></td>
<td>file prior to</td>
<td>complete, plans will have 60 days to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the 20th of</td>
<td>transmit the associated CRA data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>each month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX I - PERFORMANCE MONITORING STANDARDS

HEALTHY KIDS DENTAL
Medicaid Dental Plans

(Effective October 1, 2018 – September 30, 2019)

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of Dental 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 Dental 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 Dental Plans during the fiscal year and compares performance of each plan over time, to other Dental Plans, and to industry standards, where available.

The Performance Monitoring Standards address the following:
- Medicaid Managed Care
- Dental Quality Alliance
- HEDIS

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

Minimum performance monitoring standards for FY 2019 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.
<table>
<thead>
<tr>
<th>PERFORMANCE AREA</th>
<th>GOAL</th>
<th>MINIMUM STANDARD</th>
<th>DATA SOURCE</th>
<th>MONITORING INTERVALS</th>
</tr>
</thead>
</table>
| **Customer Services:**  
  Enrollee Complaints | Plan will have minimal Enrollee contacts through the Medicaid Helpline for issues determined to be complaints | Information Only | Customer Relations Management (CRM) | Quarterly |
| **Claims Reporting and Processing** | Dental 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 dental 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 |
<p>| <strong>Provider File Reporting</strong> | Timely and accurate provider file submission to MI Enrolls by the last Thursday of the month | Timely and accurate submission | MI Enrolls | Monthly |</p>
<table>
<thead>
<tr>
<th>PERFORMANCE AREA</th>
<th>GOAL</th>
<th>MINIMUM STANDARD</th>
<th>DATA SOURCE</th>
<th>MONITORING INTERVALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HEDIS® Annual Dental Visit</td>
<td>Annual dental visit is measured as the percentage of members 2-21 years of age who were continuously enrolled during the measurement year (allowing for a single gap of up to 45 days) who had at least one dental visit during the measurement year. The measure is reported by age cohort (2-3, 4-6, 7-10, 11-14, 15-18, and 19-20).</td>
<td>Informational Only</td>
<td>MDHHS Data Warehouse</td>
<td>Annual</td>
</tr>
<tr>
<td>• CMS-416 Enrolled Children Receiving Any Dental Services</td>
<td>Any dental services is measured as the percentage of unduplicated children who received any dental service (CDT codes D0100-D9999) during the measurement period where unduplicated means that each child is counted only once even if multiple services were received.</td>
<td>Informational Only</td>
<td>MDHHS Data Warehouse</td>
<td>Annual</td>
</tr>
<tr>
<td>• CMS-416 Enrolled Children Receiving Dental Diagnostic Services</td>
<td>Following CMS Form-416 guidance, diagnostic dental services are measured as the percentage of unduplicated children who received a diagnostic dental service as defined by CDT codes D0100-D0999 (oral evaluation) where unduplicated means that each child is counted only once even if multiple services were received.</td>
<td>Informational Only</td>
<td>MDHHS Data Warehouse</td>
<td>Annual</td>
</tr>
<tr>
<td>• CMS-416 Enrolled Children Receiving Dental Preventive Services</td>
<td>Dental preventive services are measured as the percentage of unduplicated children who received a dental preventive service (CDT codes D1000-D1999) where unduplicated means that each child is counted only once even if multiple services were received.</td>
<td>Informational Only</td>
<td>MDHHS Data Warehouse</td>
<td>Annual</td>
</tr>
</tbody>
</table>
- **CMS-416 Enrolled Children Receiving Dental Treatment Services**

  Dental treatment services are measured as the percentage of unduplicated children who received a dental treatment service (CDT codes D2000-D9999) where unduplicated means that each child is counted only once even if multiple services were received.

  - **Informational Only**
  - **MDHHS Data warehouse**
  - **Annual**
<table>
<thead>
<tr>
<th>PERFORMANCE AREA</th>
<th>GOAL</th>
<th>MINIMUM STANDARD</th>
<th>DATA SOURCE</th>
<th>MONITORING INTERVALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Utilization of Services</td>
<td>Percentage of all enrolled children under age 21 who received at least one dental service within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>• Dental/ Oral Health Services: Preventive Services</td>
<td>Percentage of all enrolled children who are at “elevated” risk (moderate/high) who received a topical fluoride application and/or sealants within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>• Treatment Services</td>
<td>Percentage of all enrolled children who received a treatment service within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>• Oral Evaluation, Dental Services</td>
<td>Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>• Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk</td>
<td>Percentage of enrolled children in the age category of 10-14 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>• Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk</td>
<td>Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Type</td>
<td>Source</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Topical Fluoride for children at Elevated Caries Risk (At least two applications)</td>
<td>Percentage of enrolled children at &quot;elevated&quot; risk (i.e., &quot;moderate&quot; or &quot;high&quot;) who received at least two topical fluoride applications as a dental service within the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>Per Member per month cost of clinical services</td>
<td>Total amount that is paid on direct provision of care (reimbursed for clinical services) per member per month for all enrolled children during the reporting year.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>Usual Source of Services</td>
<td>Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
<tr>
<td>Care Continuity</td>
<td>Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.</td>
<td>Informational Only</td>
<td>Administrative</td>
<td>Annual</td>
</tr>
</tbody>
</table>
### APPENDIX J - PERFORMANCE BONUS

<table>
<thead>
<tr>
<th>Healthy Kids Dental Plan Name</th>
<th>FY19 Performance Bonus Template</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Point Summary</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Possible Points</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Dental Plan Points</strong></td>
</tr>
<tr>
<td>Performance Improvement</td>
<td>100</td>
</tr>
<tr>
<td>Compliance Review</td>
<td>100</td>
</tr>
<tr>
<td>Focus Study</td>
<td>100</td>
</tr>
<tr>
<td>Emergency Department Utilization</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total Possible Points</strong></td>
<td><strong>400</strong></td>
</tr>
</tbody>
</table>
## APPENDIX J - PERFORMANCE BONUS (Con’t)

### PERFORMANCE BONUS TEMPLATE

<table>
<thead>
<tr>
<th>Performance Improvement Project (100 Points)</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in Training by EQRO agency and meeting all requirements of MDHHS for PIP project</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL POINTS EARNED**

### COMPLIANCE REVIEW (100 Points)

<table>
<thead>
<tr>
<th>Accreditation (10 points)</th>
<th>Provider Directory (Accuracy, Timeliness for submissions, Keep website updated *15 points each=45 points)</th>
<th>Clinical Guidelines and Dental Policy (Submit documents relating to the policy of Dental plan and their guidelines *20 points)</th>
<th>Secret Shopper Call (75% threshold reached=25 points)</th>
</tr>
</thead>
</table>

**TOTAL POINTS EARNED**

### FOCUS STUDY (100 Points)

<table>
<thead>
<tr>
<th>Community Education and Outreach Project (please refer detailed description of points allotment)=40 points</th>
<th>Information Systems Demonstration=20 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sealant Measures 6-9 yrs. (Report baseline as per MDHHS guidelines)=20 points</td>
<td>Sealant Measures 10-14 yrs. (Report baseline as per MDHHS guidelines)=20 points</td>
</tr>
</tbody>
</table>

**TOTAL POINTS EARNED**

### Emergency Department Utilization (Coordination of Dental/Medical Health Services) 100 Points

**TOTAL POINTS EARNED**
<table>
<thead>
<tr>
<th>PERFORMANCE AREA</th>
<th>CRITERIA/DELIVERABLES</th>
<th>DUE DATE AND POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Outreach and Education Project to address Oral Health Disparity</td>
<td>1. Policy/Procedure for plan-specific community outreach and education</td>
<td>For FY 2019, the dental plans must submit a multiyear plan for outreach based on the analysis of the utilization data and select a focused intervention. You will receive 20 pts for work plan and 20 points for presentation during the focus study site visit.</td>
</tr>
<tr>
<td></td>
<td>2. Dental Plans must offer evidence-based interventions that have a demonstrated ability to have the required outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Dental Plans must stratify new members on a monthly basis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Dental Plans must utilize information such as utilization data, risk status, eligibility and measure status to monitor for oral health disparities and have targeted interventions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Dental Plans must implement the U.S. DHHS Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at <a href="https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers">https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Work plan/description of intervention(s) to narrow disparities carried out during calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Submit annual report on the effectiveness of evidence-based interventions to reduce oral health disparities and promote oral health and will give a presentation during the focus study site visit.</td>
<td></td>
</tr>
<tr>
<td>PERFORMANCE AREA</td>
<td>CRITERIA/DELIVERABLES</td>
<td>GOAL</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>------</td>
</tr>
<tr>
<td>Emergency Department Utilization (Medical Dental Collaboration)</td>
<td>1. What are the key issues in ED utilization and why are they important?</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>2. Based on your review, what next steps do you propose to for exploring a solution to the important issues regarding ED utilization? Include any discussions of potential study questions and study indicators of improvement, if applicable.</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>3. What are the citations for the articles you reviewed which helped you to formulate these evidence based questions (3 to 5)?</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>4. Dental Plans are expected to develop a plan for collecting and analyzing the perspective of members who utilize the ED that will readily synthesize and compliment their Initial ED Utilization Analysis. State your plan for gathering input from members.</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>5. Select the method(s) you intend to use to gather input from members:</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>☐ Observational</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>☐ Interview</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>☐ Focus Group</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>☐ Survey</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>☐ Other</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>6. Discuss plans for involvement of any other partners in this activity. (Example: Medicaid Health Plan)</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>7. Estimate your plan regarding dates, times, and locations for gathering input from members: Date(s)/Time(s): Locations:</td>
<td>10 points</td>
</tr>
</tbody>
</table>
## APPENDIX K - FINANCIAL MONITORING STANDARDS

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Monitoring Indicator</th>
<th>Threshold</th>
<th>MDHHS Action</th>
<th>Dental Plan Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Financial</td>
<td>Working Capital</td>
<td>Below minimum</td>
<td>MDHHS written notification.</td>
<td>Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.</td>
</tr>
<tr>
<td>Quarterly Financial</td>
<td>Net Worth</td>
<td>Negative Net Worth</td>
<td>MDHHS written notification. Freeze auto assigned Enrollees.</td>
<td>Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.</td>
</tr>
<tr>
<td>Quarterly Financial</td>
<td>Medical Loss Ratio</td>
<td>85%</td>
<td>MDHHS written notification.</td>
<td>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.</td>
</tr>
<tr>
<td>Annual Financial Statement</td>
<td>Risk Based Capital (RBC)</td>
<td>150-200% RBC</td>
<td>MDHHS written notification. Limit enrollment or freeze auto assigned Enrollees.</td>
<td>Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.</td>
</tr>
<tr>
<td>Annual Financial Statement</td>
<td>RBC</td>
<td>100-149% RBC</td>
<td>MDHHS written notification including request for monthly financial statements. Freeze all enrollments.</td>
<td>Submit written business plan (if not previously submitted) within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.</td>
</tr>
<tr>
<td>Annual Financial Statement</td>
<td>RBC</td>
<td>Less than 100% RBC</td>
<td>Freeze all enrollments. Terminate contract.</td>
<td>Develop transition plan.</td>
</tr>
</tbody>
</table>
APPENDIX L - MICHIGAN DENTAL PERIODICITY SCHEDULE

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

<table>
<thead>
<tr>
<th>AMERICAN ACADEMY OF PEDIATRIC DENTISTRY</th>
<th>AGE</th>
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<tr>
<td></td>
<td>6 TO 12 MONTHS</td>
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<tr>
<td>Clinical oral examination 1</td>
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<td>Assess oral growth and development 2</td>
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<td>Caries risk assessment 3</td>
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<td>Prophylaxis and topical fluoride 5,6</td>
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<td>Oral hygiene counseling 9</td>
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<td>Counseling for speech/language development</td>
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<td>Substance abuse counseling</td>
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<td>Counseling for Intraoral/periapical piercing</td>
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<tr>
<td>Assessment and treatment of developing malocclusion</td>
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<td>Assessment for pit and fissure sealants 13</td>
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<tr>
<td>Assessment and/or removal of third molars</td>
<td>✔</td>
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<tr>
<td>Transition to adult dental care</td>
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1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 10 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment, initially discuss appropriate flossing practices, then the role of refined carbohydrates and frequency of snacking in cavity development and childhood obesity.
9. Initially play objects, pacifiers, or soaks; when learning to walk, then with sports and routine play, including the importance of mouthguards.
10. At first, discuss need for additional sealants; digits vs. pacifiers, then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescents, patients, counsel regarding any existing habits such as fingernail biting, chewing, or bruxism. Finally, for caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.
The purpose of this policy is to provide clarification of Covered Services and to define "medically necessary" as it pertains to the EPSDT program. The intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions whether or not such services are covered under the State plan.\(^1\) State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age.

EPSDT visits cover any medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are available to all children for the purpose of screening and identifying children that may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, trauma, failure to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations.

EPSDT visits are to be performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. Michigan recognizes the AAP definition of "medical necessity" as:

> Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.\(^2\)

EPSDT also requires coverage of medically necessary interperiodic screening outside of the State's periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.\(^3\)

Medically necessary services include habilitative or rehabilitative services that are expected to attain, maintain, or regain functional capacity and to achieve maximum health and function. The Centers for Medicare & Medicaid Services (CMS) indicated a service need not cure a condition in order to be covered under EPSDT, and that maintenance services or services that improve the child's current health condition are also covered in EPSDT because they ameliorate a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. It is important to identify illnesses and conditions early and to treat any health problems discovered in children before they become worse and more costly. A medically necessary treatment service should not be denied to a child based on cost alone, but the relative cost effectiveness of alternative services may be considered as part of the prior authorization process. Services may be covered in the in
the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child’s needs individually. Prior authorization is not required for medically necessary screenings.³

Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of ameliorate is “to make more tolerable.” Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose.³

CMS specified that EPSDT includes a broad range of services that can be covered and includes licensed practitioners’ services; speech, occupational, and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and Dental Services.⁴ In addition, the coverage of other diagnostic, screening, preventive and rehabilitative services is required, and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.¹

CMS maintains that the coverage of EPSDT services is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other, less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit.³

The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular physical, behavioral, mental, or dental health needs of the child. While the treating Provider is responsible for determining or recommending that a particular service is needed to correct the child’s condition, both the MDHHS and a child's treating Provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating Provider, health plan, and/or Medicaid as to whether a service is medically necessary for a particular child, Medicaid is responsible for making a decision for the individual child based on information presented to departmental staff. The MDHHS Office of Medical Affairs consists of a panel of physicians, including pediatricians, who will review the medical necessity of a particular service when there is a disagreement between the treating Provider, health plan or Medicaid. These physicians review, on a case by case basis, the particular needs of the child based on the medical standards and literature, and in consultation with subspecialists when appropriate in accordance with Michigan Medicaid policy.

Manual Maintenance
Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions
Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Chris Priest, Director
Medical Services Administration

References
APPENDIX N - HIPAA BUSINESS ASSOCIATE AGREEMENT ADDENDUM

The parties to this Business Associate Addendum (Addendum) are the State of Michigan, acting by and through the Department of Technology, Management and Budget, on behalf of Michigan Department of Health and Human Services (State) and Delta Dental Plan of Michigan, Inc. (Contractor). This Addendum supplements and is made a part of the existing contracts between the parties including the following Contract(s): Healthy Kids Dental Program (Contract).

For purposes of this Addendum, the State is: Covered Entity (CE) and the Contractor is: Business Associate (Associate).

RECITALS

A. Under the terms of the Contract, CE wishes to disclose certain information to Associate, some of which may constitute Protected Health Information or Personally Identifiable Information (collectively, Protected Information). In consideration of the receipt of such information, Associate agrees to protect the privacy and security of the information as set forth in this Addendum.

B. CE and Associate intend to protect the privacy and provide for the security of Protected Information disclosed to Associate under the Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Public Law 111-5, regulations promulgated by the U.S. Department of Health and Human Services (DHHS) (HIPAA Rules) and other applicable laws, as amended.

C. As part of the HIPAA Rules, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with Associate prior to the disclosure of Protected Health Information, as set forth in, but not limited to, 45 CFR Parts 160 and 164 and the HITECH Act, and as otherwise contained in this Addendum. In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. Definitions.
   a. Except as otherwise defined herein, capitalized terms in this Addendum have the same meaning as those terms under HIPAA, the HITECH Act, and the HIPAA Rules.
   b. “Agent” has the same meaning given to the term under the federal common law of agency.
   c. “Agreement” means the Contract and this Addendum, as read together.
   d. “Breach” means the acquisition, access, Use or Disclosure of Protected Health Information or Personal Identifying Information in a manner not permitted under the Privacy Rule or the Michigan Identify Theft Protection Act, as applicable, which compromises the security or privacy of such information.
   e. “Contract” means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added. Contract also includes all amendments and addendums to the original contract, both effective before and effective after the date of this Addendum.
   f. “Designated Record Set” has the same meaning as the term under 45 CFR §164.501.
   g. “Disclosure” means, the release, transfer, provision of access to, or divulging of Protected Information in any manner outside the entity holding the information.
   h. “Electronic Health Record” has the same meaning as the term under Section 13400 of the HITECH Act.
   i. “Electronic Protected Health Information” or “Electronic PHI” has the same meaning as the term under 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Associate on behalf of CE.
   k. “HITECH Act” means The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, specifically Division A: Title XIII Subtitle D—Privacy, and its corresponding regulations as enacted under the authority of the Act.
   m. “Individual” has the same meaning as the term under 45 CFR §160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR §165.502(g).
   n. “Personal Identifying Information” or “PII” has the same meaning as the term Section 3(q) of the Identity Theft Protection Act.
   o. “Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
“Protected Health Information” or “PHI” has the meaning given to the term under the Privacy Rule, 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Associate on behalf of CE.

“Protected Information” means PHI and PII created, received, maintained or transmitted by Associate on behalf of CE.

“Security Incident” means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of Protected Information or interference with system operations in an information system.


“Subcontractor” means a person or entity that creates, receives, maintains, or transmits Protected Information on behalf of Associate and who is now considered a Business Associate, as the latter term is defined in 45 CFR §160.103.

“Unsecured Protected Health Information” or “Unsecured PHI” means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by DHHS as defined in the Breach Rule, 45 CFR §164.402.

“Use” means, with respect to Protected Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

2. Obligations and Activities of Associate.

a. Permitted Uses and Disclosures. Associate may Use and Disclose Protected Information only as necessary to perform services owed CE under the Contract and meet its obligations under this Addendum, provided that such Use or Disclosure would not violate the Privacy Rule, the privacy provisions of the HITECH Act or the Identity Theft Protection Act, if done by CE. All other Uses or Disclosures by Associate not authorized by this Addendum, or by specific written instruction of CE, are prohibited. Except as otherwise limited by this Addendum, Associate may Use and Disclose Protected Information as follows:

i. Associate may Use Protected Information for the proper management and administration of the Associate or to carry out the legal responsibilities of the Associate.

ii. Associate may Disclose Protected Information for the proper management and administration of the Associate, provided that Disclosures are Required by Law; or Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used, or further Disclosed, only as Required by Law, or for the purpose for which it was Disclosed to the person, and the person notifies the Associate of any instances of which it is aware that the confidentiality of the information has been breached.

iii. Associate may Use Protected Health Information to provide Data Aggregation services to CE for the Health Care Operations of CE, as permitted by 45 CFR §164.504(e)(2)(i)(B). Associate agrees that said services shall not be provided in a manner that would result in Disclosure of Protected Health Information to another CE who was not the originator or lawful possessor of said information. Further, Associate agrees that any such wrongful Disclosure of Protected Health Information constitutes a Breach and shall be reported to CE in accordance with this Addendum.

iv. Associate may Use Protected Health Information to report violations of law to appropriate federal and state authorities, consistent with 45 CFR §164.502(j)(1).

b. Appropriate Safeguards. Associate must implement appropriate safeguards to protect against the Use or Disclosure of Protected Information other than as permitted by this Addendum so as to comply with the HIPAA Rules, the HITECH Act, and applicable state laws and maintain written policies concerning the same. Associate must implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Information, including specifically Electronic PHI, as provided for in the Security Rule and as mandated by Section 13401 of the HITECH Act. These safeguards shall include, at minimum:

i. Achieving and maintaining compliance with the HIPAA Security Rule, as necessary in conducting operations on behalf of CE under this Addendum.

ii. Providing a level and scope of security that is at least comparable to the level and scope of security established by the National Institute of Standards and Technology (NIST) in NIST 800-53, Recommended Security Controls for Federal Information Systems, Annex 2: Consolidated Security Controls-Moderate Baseline. The oldest acceptable version is the
most recently approved version of NIST that has been approved for 6 months or more; however, Associate is encouraged to adopt newly approved versions of NIST as soon as practicable. If Associate chooses to use the Control Objectives for Information and Related Technology (COBIT), Information Systems Audit and Control Association (ISACA), or International Organization for Standardization (ISO) standards, Associate must demonstrate and document how each aspect of the chosen standard comports with the applicable version of NIST and make such documentation available to CE upon request. If Associate uses a standard other than those described in this subsection, Associate must demonstrate and document how each aspect of the chosen standard comports with the appropriate version of NIST and present to CE for review and approval. Additionally, whichever standard is chosen must comport with HIPAA Rules, including specifically the Security Rule and Privacy Rule.


iv. In case of a conflict between any of the security standards contained in any of these enumerated sources, the most stringent shall apply. The most stringent means those safeguards that provide the highest level of protection to Protected Information from unauthorized Disclosure. Further, Associate must comply with changes to these standards that occur after the effective date of this Addendum.

v. Upon request, Associate must provide CE with all information security and privacy policies, disaster recovery and business continuity policies, network connectivity diagrams, and all other security measures implemented by Associate.

c. Security Incidents. Associate must notify and report to CE in the manner described herein any Security Incident, whether actual or suspected, and any Use or Disclosure of Protected Information in violation of this Addendum, and take the following actions:

i. Notice to CE. Associate must notify CE, via e-mail and telephone, within five (5) business days of the discovery of any Security Incident or any Use or Disclosure of Protected Information in violation of this Addendum. Associate must follow its notification to CE with a report that meets the requirements outlined immediately below.

ii. Investigation; Report to CE. Associate must promptly investigate any Security Incident. Within ten (10) business days of the discovery, Associate must submit a preliminary report to CE identifying, to the extent known at the time, any information relevant to ascertaining the nature and scope of the Security Incident. Within fifteen (15) business days of the discovery of the Security Incident and unless otherwise directed by CE in writing, Associate must provide a complete report of the investigation to CE. Such report shall identify, to the extent possible: (a) each individual whose Protected Information has been, or is reasonably believed by Associate to have been accessed, acquired, Used or Disclosed; (b) the type of Protected Information accessed, Used or Disclosed (e.g., name, social security number, date of birth) and whether such information was Unsecured; (c) who made the access, Use, or Disclosure; and (d) an assessment of all known factors relevant to a determination of whether a Breach occurred under applicable provisions of HIPAA, the HIPAA Rules, the HITECH Act, or a Breach of Security under the Identity Theft Protection Act, and any other applicable federal or state regulations. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and contain any improper Use or Disclosure. If CE requests information in addition to that listed in the report, Associate shall make reasonable efforts to provide CE with such information. Associate agrees that CE reserves the right to review and recommend changes to any corrective action plan and make a final determination as to whether a Breach of PHI or PII occurred and whether any notifications may be required under applicable state or federal regulations, including Section 13402 of the HITECH Act. In the event of a Breach of Unsecured PHI, as determined by CE, Associate agrees, consistent with 45 CFR §164.404(c), Section 13402 of the HITECH Act and Section 12 of the Identity Theft Protection Act, as applicable, to provide CE with information and documentation in its control necessary to meet the requirements of said sections, and in a manner and format to be reasonably specified by CE.

iii. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a Security Incident or a Use or Disclosure of Protected Information in violation of the requirements of this Addendum. Associate must take: (a) prompt corrective action to cure any such violation and (b) any other action pertaining to such unauthorized Use or Disclosure required by applicable federal and state laws and regulations.
d. **Responsibility for Notifications.** If the cause of a Breach of Protected Information is attributable to Associate or its Agents or Subcontractors, Associate is responsible for all required reporting and notifications of the Breach as specified in and in accordance with Section 13402 of the HITECH Act and the Identity Theft Protection Act, as applicable, unless CE notifies Associate in writing that CE intends to be responsible for said reporting and notifications. In all cases, CE’s authorized representative shall approve the time, manner, and content of any such notification and its approval must be obtained before the notification is made. In the event of such Breach, and without limiting Associate’s obligations of indemnification as further described in this Addendum, Associate must indemnify, defend, and hold harmless CE for any and all claims or losses, including reasonable attorneys’ fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from CE in connection with the occurrence.

e. **Associate’s Agents and Subcontractors.** If Associate uses one or more Subcontractors or Agents to provide services under the Agreement, and such Agents or Subcontractors receive or have access to Protected Information, each Subcontractor or Agent must sign an agreement with Associate containing substantially the same provisions as this Addendum and in conformance with 45 CFR §164.504(e)(2), and to assume toward Associate all of the obligations and responsibilities that the Associate, by this Addendum, assumes toward CE. Associate agrees to provide said Agents or Subcontractors PHI in accordance with the HIPAA Rules, the HITECH Act, and PII in accordance with applicable federal and state law and must: (i) implement and maintain sanctions against Subcontractors and Agents that violate such restrictions and conditions; and (ii) mitigate, to the extent practicable, the effects of any such violation.

f. **Access to Protected Health Information.** Associate agrees to make PHI regarding an Individual maintained by Associate or its Agents or Subcontractors in a Designated Record Set available to such Individual for inspection and copying in order to meet CE’s obligations under 45 CFR §164.524. An Individual’s request for access must be submitted on standard request forms available from Associate. If CE receives a request for access, CE, in addition to addressing the request on its behalf, will forward the request in writing to Associate in a timely manner. If Associate or its Agents or Subcontractors maintain Electronic Health Records for CE, then Associate must provide, where applicable, electronic access to the Electronic Health Records to CE.

g. **Amendment of Protected Health Information.** Associate agrees to make any amendment(s) to PHI in a Designated Record Set to meet CE’s obligations under 45 CFR §164.526. An Individual’s amendment request must be submitted on standard forms available from Associate. If CE receives a request for an amendment, CE, in addition to addressing the request on its behalf, will forward the request in writing to Associate in a timely manner.

h. **Accounting Rights.** Associate agrees to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR §164.528. Associate must maintain necessary and sufficient documentation of Disclosures of PHI and information related to such Disclosures as would be required for CE to respond to a request by an Individual for an accounting of Disclosures under 45 CFR §164.528. An Individual’s request for a report of accounting must be submitted on standard request forms available from Associate. If CE receives a request for an accounting, CE, in addition to addressing the request on its own behalf, will forward the request in writing to Associate in a timely manner. Associate must also comply with the requirements of Section 13405(c) of the HITECH Act, as applicable.

i. **Access to Records and Internal Practices.** Unless otherwise protected or prohibited from discovery or Disclosure by law, Associate must make its internal practices, books, and records, including policies and procedures (collectively, Compliance Information), relating to the Use or Disclosure of PHI and PII and the protection of same, available to CE or to the Secretary of DHHS (Secretary) for purposes of the Secretary determining CE’s compliance with the HIPAA Rules and the HITECH Act. Associate shall have a reasonable time within which to comply with requests for such access, consistent with this Addendum. In no case shall access be required in less than five (5) business days after Associate’s receipt of such request, unless otherwise designated by the Secretary.

j. **Minimum Necessary.** Associate (and its Agents or Subcontractors) shall only request, Use and Disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, Use or Disclosure, in accordance with the Minimum Necessary requirements of the Privacy Rule, including, but not limited to 45 CFR §§ 164.502(b) and 164.514(d) and the HITECH Act.

k. **Compliance.**

i. To the extent that Associate carries out one or more of CE’s obligations under the HIPAA Rules, Associate must comply with all requirements that would be applicable to CE.
Associate must honor all restrictions consistent with 45 CFR §164.522 that CE or the Individual makes Associate aware of, including the Individual’s right to restrict certain Disclosures of PHI to a health plan where the Individual pays out of pocket or in full for the healthcare item or service, in accordance with Section 13405(a) of the HITECH Act.

Data Ownership. Unless otherwise specified in this Addendum, Associate agrees that Associate has no ownership rights with respect to the Protected Information and that CE retains all rights with respect to ownership of such information. Associate further agrees not to receive remuneration, directly or indirectly, in exchange for Protected Information, except with the prior written consent of CE.

Retention of Protected Information. Notwithstanding Section 5(d) of this Addendum, Associate and its Subcontractors or Agents shall retain all Protected Information throughout the term of the Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) years from the date of creation or the date when it last was in effect, whichever is later, or as Required by Law. This obligation shall survive the termination of the Contract.

Audit Findings. Associate must implement any appropriate Safeguards, as identified by CE in an audit conducted under paragraph 2(o).

Reserved.

Safeguards During Transmission. Associate must utilize safeguards that reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of Protected Information transmitted to CE under this Addendum, in accordance with the standards and requirements of the HIPAA Rules and other applicable federal or state regulations, until such Protected Information is received by CE, and in accordance with any specifications set forth in Attachment A.

Due Diligence. Associate must exercise due diligence and take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HIPAA Rules, the HITECH Act and other applicable laws or regulations pertaining to Protected Information, and that its Agents, Subcontractors and vendors are in compliance with their obligations as required by this Addendum.

Sanctions and Penalties. Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act, the HIPAA Rules or any other state or federal regulation that is applicable to Associate may result in the imposition of sanctions or penalties on Associate under HIPAA, the HIPAA Rules, the HITECH Act, or any other applicable laws or regulations pertaining to PHI and PII.

Indemnification. Associate shall indemnify, hold harmless and defend CE from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Associate or its Agents or Subcontractors in connection with the representations,
duties, and obligations of Associate under this Addendum, including but not limited to any unauthorized Use or Disclosure of Protected Information. This includes credit-monitoring services, third party audits of Associate’s handling and remediation of the Breach, and reimbursement for State employee time spent handling the Security Incident, as reasonably deemed appropriate by CE. The parties’ respective rights and obligations under this subsection shall survive termination of the Agreement.

3. **Obligations of CE.**

   a. **Safeguards During Transmission.** CE must utilize safeguards that reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of Protected Information transmitted to Associate under this Addendum, in accordance with the standards and requirements of the HIPAA Rules and other applicable federal or state regulations, until such Protected Information is received by Associate, and in accordance with any specifications set forth in Attachment A.

   b. **Notice of Limitations and Changes.** CE must notify Associate of any limitations in its notice of privacy practices in accordance with 45 CFR §164.520, or any restriction to the Use or Disclosure of PHI that CE has agreed to in accordance with 45 CFR §164.528, to the extent that such limitation may affect Associate’s Use or Disclosure of PHI. CE must also notify Associate of any changes in, or revocation of, permission by Individual to Use or Disclose PHI of which it becomes aware, to the extent that such changes may affect Associate’s Use or Disclosure of PHI.

4. **Term.** This Addendum shall continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Rules and the HITECH Act, whichever first occurs. However, certain obligations will continue as specified in this Addendum.

5. **Termination.**

   a. **Material Breach.** Except as otherwise provided in the Contract, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of the Agreement and provide grounds for CE to terminate the Agreement for cause, subject to section 5(b):

      i. **Default.** If Associate refuses or fails to timely perform any of the provisions of this Addendum, CE may notify Associate in writing of the non-performance, and if not corrected within thirty (30) days, CE may immediately terminate the Agreement. Associate agrees to continue performance of the Agreement to the extent it is not terminated.

      ii. **Duties.** Notwithstanding termination of the Agreement, and subject to any reasonable directions from the CE, Associate agrees to take timely, reasonable and necessary action to protect and preserve property in the possession of the Associate in which CE has an interest.

      iii. **Erroneous Termination for Default.** If after such termination it is determined, for any reason, that Associate was not in default, or that Associate’s action or inaction was excusable, such termination shall be treated as a termination for convenience, and the rights and obligations of the parties shall be the same as if the Contract had been terminated for convenience, as described in this Addendum or in the Contract.

   b. **Reasonable Steps to Cure Breach.** If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate’s obligations under the provisions of this Addendum or another arrangement and does not terminate the Agreement under Section 5(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE’s efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, CE shall report Associate’s breach or violation to the Secretary.

   c. **Reserved.**

   d. **Effect of Termination.**

      (i) At the direction of CE, and except as provided in section 5(d)(ii), upon termination of the Agreement for any reason, Associate must return or destroy all Protected Information that Associate or its Agents or Subcontractors still maintain in any form, and shall retain no copies of such information. If CE directs Associate to destroy the Protected Information, Associate must certify in writing to CE that such information has been destroyed. If CE directs associate to return such information, Associate must do so promptly in any format reasonably specified by CE.

      (ii) If Associate believes that returning or destroying the Protected Information is not feasible, including but not limited to, a finding that record retention requirements provided by law make return or destruction infeasible, Associate must promptly provide CE written notice
of the conditions making return or destruction infeasible. Upon mutual agreement of CE and Associate that return or destruction of Protected Information is infeasible, Associate must continue to extend the protections of this Addendum to such information, and must limit further Use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible.

6. Reserved.
7. No Waiver of Immunity. No term or condition of this Addendum shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of applicable laws, including the Michigan Governmental Immunity Act, MCL 691.1401, et seq., the Court of Claims Act, MCL 600.6401, et seq., the Federal Tort Claims Act, 28 U.S.C. 2671, et seq., or the common law, as applicable, as now in effect or hereafter amended.

8. Reserved.
9. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Addendum, HIPAA, the HIPAA Rules, the HITECH Act or other applicable laws pertaining to Protected Information will be adequate or satisfactory for Associate’s own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of Protected Information.

10. Reserved.
11. Amendment.
   a. Amendment to Comply with Law. The parties agree to take such action as is necessary to amend this Addendum from time to time as may be necessary for CE and Associate to comply with and implement the standards and requirements of HIPAA, the Privacy Rule, the Security Rule, the Breach Rule, the HITECH Act, the Identity Theft Protection Act, and other applicable laws relating to the security or privacy of PHI and PII. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule, the Security Rule, the Breach Rule, the HITECH Act, the Identity Theft Protection Act, or other applicable laws. Either party may terminate the Agreement upon thirty (30) days written notice if (i) the other does not promptly enter into negotiations to amend this Agreement when requested by the requesting party under this Section or (ii) the non-requesting party does not enter into an amendment to this Agreement when requested providing assurances regarding the safeguarding of PHI and PII that the requesting party, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Rules, the HITECH Act, the Identity Theft Protection Act, and other applicable laws.
   b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

12. Assistance in Litigation or Administrative Proceedings. Associate must make itself, and any Subcontractors, employees or Agents assisting it in the performance of its obligations under this Addendum available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against a party, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA, the HITECH Act, the HIPAA Rules, the Identity Theft Protection Act, or other laws relating to security and privacy of Protected Information, except where the other party 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, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract shall remain in force and effect. This Addendum is incorporated into the Contract as if set forth in full therein. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Associate and CE expressly waive any claim or defense that this Addendum is not part of the Agreement between the parties under the Contract.

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

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

17. **Survival of Certain Contract Terms.** Notwithstanding anything herein to the contrary, Associate’s obligations under Section 2(d) (Responsibility for Notifications), Section 2(u) (Indemnification), Section 5(d) (Effect of Termination), Section 12 (Assistance in Litigation or Administrative Proceedings), Section 13 (No Third Party Beneficiaries), and applicable record retention laws shall survive termination of this Agreement and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate.

18. **Representatives and Notice.**
   a. **Representatives.** For the purpose of this Addendum, the individuals identified in the Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby designated as the parties’ respective representatives for purposes of this Addendum. Either party may from time to time designate in writing new or substitute representatives.
   b. **Notices.** Except as otherwise provided in this Addendum, all required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

**Covered Entity Representative:**

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

**Business Associate Representative:**

Name: _________________________  
Title: _________________________  
Department: _________________________  
Division: _________________________  
Address: _________________________  
_________________________  
_________________________

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

**IN WITNESS WHEREOF,** the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

**Associate**

By: _____________________________  
Print Name: _________________________  
Title: _________________________

**Covered Entity**

By: _____________________________  
Print Name: Christine Sanches  
Title: Director, Bureau of Budget and Purchasing
## APPENDIX O - SUBCONTRACTOR TEMPLATE

**Provider Subcontractors**

**Contract Authority:**

**Dental Plan:**

For more than two Subcontractors per category duplicate page(s)

Due Date: January 15

<table>
<thead>
<tr>
<th>Category I</th>
<th>Administrative A, B or C</th>
<th>Notify MDHHS at least 21 calendar days prior to the effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category I</td>
<td>Administrative A, B or C</td>
<td>Notify MDHHS at least 21 calendar days prior to the effective date</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Full Name of Subcontractor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcontractor Street Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Administrative A, B or C Description of Work to be Subcontracted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Effective Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDHHS Original Notification Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX P - CONTRACTOR COMPLIANCE REVIEW

<table>
<thead>
<tr>
<th></th>
<th>January 15</th>
<th>April 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Contract Table</td>
<td>Annual report of ID card mailing dates</td>
<td></td>
</tr>
<tr>
<td>Subcontract Table</td>
<td>Review Member Handbook</td>
<td></td>
</tr>
<tr>
<td>Subcontractor Monitoring Documentation</td>
<td>Evidence of Beneficiary requests and fulfillment for printed handbooks</td>
<td></td>
</tr>
<tr>
<td>Subcontractor Prior Authorization Policy and Procedure</td>
<td>Member Newsletters (no submission)</td>
<td></td>
</tr>
<tr>
<td>Agreement Tables</td>
<td>Management Discussion and Analysis for Annual Financial (Consolidated Annual Report)</td>
<td></td>
</tr>
<tr>
<td>Provider Authorization/Emergent Provider Authorization</td>
<td>OIG Program Integrity Compliance Plan - proof of admin and management arrangements or procedures including a mandatory compliance plan</td>
<td></td>
</tr>
<tr>
<td>Provider Network Table</td>
<td>May 15</td>
<td></td>
</tr>
<tr>
<td>Policy and/or procedures for maintaining communication with Providers</td>
<td>Policies and procedures for Grievance and Appeals</td>
<td></td>
</tr>
<tr>
<td>Provider Appeal Log</td>
<td>Member Grievance and Appeal Log (Apr-Mar)</td>
<td></td>
</tr>
<tr>
<td>Current accreditation certificate or accreditation organization letter</td>
<td>Performance Monitoring Report</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Guidelines Table</td>
<td>February 15</td>
<td>Third Party Liability Recovery policies and procedures</td>
</tr>
<tr>
<td>Final Approved Policies and Procedures for CPGs</td>
<td>Program Integrity Reports (Jan-Mar)</td>
<td></td>
</tr>
<tr>
<td>Program Integrity Reports (Oct-Dec)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 15</td>
<td>June 15</td>
<td></td>
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<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Quality Improvement Project evaluation and work plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization Management Program and effectiveness review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Oral Health Promotion and Outreach Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Chart</td>
<td>QI &amp; UM policies and procedures</td>
<td></td>
</tr>
<tr>
<td>Administrative Position Description</td>
<td>MIS Operational plan and screen prints</td>
<td></td>
</tr>
<tr>
<td>Governing Body - Board member information</td>
<td>Written procedure to electronically process enrollments and disenrollments</td>
<td></td>
</tr>
<tr>
<td>Provider Directory review</td>
<td>Audited Financial Statements</td>
<td></td>
</tr>
<tr>
<td>Consolidated Annual Report (CY 16):</td>
<td>July 15</td>
<td></td>
</tr>
<tr>
<td>- MSA 126 Health Plan Profile</td>
<td>HEDIS IDSS</td>
<td></td>
</tr>
<tr>
<td>- NAIC</td>
<td>Performance Improvement Plans (not EQRO PIP)</td>
<td></td>
</tr>
<tr>
<td>- MSA 2012 Health Plan Data Certification Form</td>
<td>Program Integrity - Provider enrollment, screening and disclosure requirements</td>
<td></td>
</tr>
<tr>
<td>- MSA 129 Litigation Report</td>
<td>August 15</td>
<td></td>
</tr>
<tr>
<td>- Physician Incentive Program (PIP) Attestation Form</td>
<td>Annual Audit findings from 3rd party audit of data privacy and info security</td>
<td></td>
</tr>
<tr>
<td>- Physician Incentive Program (PIP) Disclosure forms</td>
<td>Medicaid Health Equity Template</td>
<td></td>
</tr>
<tr>
<td>- Provider Manual</td>
<td>HEDIS Compliance Audit - Final Audit Report</td>
<td></td>
</tr>
<tr>
<td>- Certificate of Coverage</td>
<td>Program Integrity Reports (Apr-Jun)</td>
<td></td>
</tr>
<tr>
<td>- Member Handbook</td>
<td>Nov 15</td>
<td></td>
</tr>
<tr>
<td>- EPSDT Requirements - Incentives, list with brief description, member incentives offered to increase member utilization of EPSDT services</td>
<td>Program Integrity reports (JUL-SEP)</td>
<td></td>
</tr>
<tr>
<td>- EPSDT Requirements - List with brief description, Provider incentives offered to increase monitoring of providing EPSDT services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX P1: COMPLIANCE REVIEW-Program Integrity

<table>
<thead>
<tr>
<th>Report Reference</th>
<th>Due Date</th>
<th>Period Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Submissions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Program Integrity Plan for Michigan Medicaid</td>
<td>June 15, 2019</td>
<td>FY 2020: 10/1/19 - 9/30/20</td>
</tr>
<tr>
<td></td>
<td>June 15, 2020</td>
<td>FY 2021: 10/1/20 – 9/30/21</td>
</tr>
<tr>
<td></td>
<td>June 15, 2021</td>
<td>FY 2022: 10/1/21 – 9/30/22</td>
</tr>
<tr>
<td>Annual Program Integrity Report for Michigan Medicaid</td>
<td>June 15, 2019</td>
<td>FY 2018: 10/1/18 - 9/30/19</td>
</tr>
<tr>
<td></td>
<td>June 15, 2020</td>
<td>FY 2019: 10/1/19 - 9/30/20</td>
</tr>
<tr>
<td></td>
<td>June 15, 2021</td>
<td>FY 2020: 10/1/20 – 9/30/21</td>
</tr>
<tr>
<td><strong>Quarterly Submissions (previous months reporting)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly EOB Log</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<tr>
<td></td>
<td>August 15, 2019</td>
<td>April 1, 2019-June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Data Mining/Algorithm Log</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<tr>
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<td>April 1, 2019-June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Tips and Grievances Log</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<tr>
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<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Overpayments Identified Reporting Form</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
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<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<tr>
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<td>August 15, 2019</td>
<td>April 1, 2019-June 30, 2019</td>
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<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Recoveries Reporting Form</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
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<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<td>August 15, 2019</td>
<td>April 1, 2019-June 30, 2019</td>
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<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Fraud Referral Log</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<td>August 15, 2019</td>
<td>April 1, 2019-June 30, 2019</td>
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<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
</tr>
<tr>
<td>Quarterly Provider Disenrollment Log</td>
<td>February 15, 2019</td>
<td>October 1, 2018-December 31, 2018</td>
</tr>
<tr>
<td></td>
<td>May 15, 2019</td>
<td>January 1, 2019 –March 31, 2019</td>
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<tr>
<td></td>
<td>August 15, 2019</td>
<td>April 1, 2019-June 30, 2019</td>
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<tr>
<td></td>
<td>November 15, 2019</td>
<td>July 31, 2019 –September 30, 2019</td>
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<tr>
<td><strong>On Request, or while Onsite</strong></td>
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<tr>
<td>---------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Records</td>
<td>Within three Business Days from the date of request unless otherwise specified by MDHHS OIG.</td>
<td></td>
</tr>
<tr>
<td><strong>Ad HOC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud Referral Form</td>
<td>Within five Business Days from the date of determining a credible allegation of fraud exists.</td>
<td></td>
</tr>
<tr>
<td>Prepayment Review Request Form</td>
<td>Must be approved by MDHHS OIG prior to implementing any prepayment review.</td>
<td></td>
</tr>
<tr>
<td>Excluded Individual Reporting Form</td>
<td>Within 20 Business Days of the date of discovery/disclosure.</td>
<td></td>
</tr>
<tr>
<td>Network Provider Adverse Action Reporting Form</td>
<td>Within 20 Business Days of any adverse actions taken by the Contractor.</td>
<td></td>
</tr>
</tbody>
</table>
The State of Michigan Managed Care Rates will be paid within the certified, actuarially sound rate range, Fiscal Year 2019 Healthy Kids Dental rates are effective from October 1, 2018, through September 30, 2019.

Subsequent Fiscal Years under this Contract will have 12 month rate-setting periods from October 1 through September 30 of the respective Fiscal Year which correspond to the Contract year. If rates require recertification during the Contract year, a Contract amendment will be issued. Rates will be distributed under a separate cover and are incorporated herein by reference.
<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The terms used in this Contract must be construed and interpreted as defined below unless the Contract otherwise expressly requires a different interpretation:</td>
<td></td>
</tr>
<tr>
<td>Abuse</td>
<td>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)</td>
</tr>
<tr>
<td>Adverse Benefit Determination</td>
<td>An action or inaction by the Contractor including 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 service. (4) The failure to provide services in a timely manner, as defined in this Contract. (5) The failure of the Contractor to act within the timeframes provided in 438.408(b)(1) and (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.</td>
</tr>
<tr>
<td>Agent (of the entity)</td>
<td>Any person who has express or implied authority to obligate or act on behalf of the State, Contractor, Subcontractor, or Network Provider.</td>
</tr>
<tr>
<td>Appeal</td>
<td>Review by the Contractor of an Adverse Benefit Determination.</td>
</tr>
<tr>
<td>Beneficiary</td>
<td>A Child determined eligible for the Medicaid program dental benefit.</td>
</tr>
<tr>
<td>Blanket Purchase Order (BPO)</td>
<td>Alternative term for “Contract” used in the State’s computer system Michigan Automated Information Network (MAIN).</td>
</tr>
<tr>
<td>Business Day</td>
<td>Monday through Friday, 8:00 AM through 5:00 PM EST (unless otherwise stated) not including State or federal holidays.</td>
</tr>
<tr>
<td>CAHPS®</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
</tr>
<tr>
<td>Capitated Rate</td>
<td>A fixed per person monthly rate payable to the Contractor by MDHHS for provision of all Covered Services defined within this Contract.</td>
</tr>
<tr>
<td>Capitation Payment (see Capitated Rate)</td>
<td>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.</td>
</tr>
<tr>
<td>Caries Risk Assessment (CRA)</td>
<td>A tool developed by the American Dental Association to assess an individual's oral risk factors, protective factors and clinical findings related to dental caries adopted by MDHHS for HKD Beneficiaries.</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services (CMS)</td>
<td>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.</td>
</tr>
<tr>
<td>Child</td>
<td>An individual under the Age of 21.</td>
</tr>
<tr>
<td>Children with Special Needs</td>
<td>HKD beneficiaries with special health care needs including but not limited to children with physical, mental and/or behavioral health disabilities or impairment, autistic children, children in Foster Care and CSHCS programs.</td>
</tr>
<tr>
<td>Children's Special Health Care Services (CSHCS)</td>
<td>A program for individuals with a qualifying health condition(s) eligible to receive services under Title V of the Federal Social Security Act.</td>
</tr>
<tr>
<td>Children’s Health Insurance Program (CHIP)</td>
<td>The CHIP was created by the Balanced Budget Act of 1997 and enacted Title XXI of the Social Security Act. CHIP is a joint state-federal partnership that provides health insurance to low-income children.</td>
</tr>
<tr>
<td>TERM</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clean Claim</td>
<td>All claims as defined in 42 CFR §447.45 and MCL 400.111i.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>A process of working with others to achieve shared goals.</td>
</tr>
<tr>
<td>Community Collaboration</td>
<td>A plan for developing policies and defining actions to improve Population Health.</td>
</tr>
<tr>
<td>Community Health Workers (CHWs)</td>
<td>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.</td>
</tr>
<tr>
<td>Complaint</td>
<td>A communication by a Beneficiary or a Beneficiary's representative to the Contractor expressing a concern about care or service provided by the Contractor or dental provider presenting an issue with a request for remedy that can be resolved informally. Complaints may be oral or written.</td>
</tr>
<tr>
<td>Contract</td>
<td>A binding agreement entered into by the State of Michigan and the Contractor; see also “Blanket Purchase Order.”</td>
</tr>
<tr>
<td>Contractor</td>
<td>An entity that enters into agreement with the State of Michigan to provide the scope of services required under this Contract.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>All Dental Services provided under Medicaid, as defined in Schedule A, section 1.0, which the Contractor has agreed to provide or arrange to be provided under the terms of this Contract.</td>
</tr>
<tr>
<td>Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>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.</td>
</tr>
<tr>
<td>Data Exchange Gateway (DEG)</td>
<td>A secure electronic location for files to be transferred between MDHHS, Contractors and their Agents.</td>
</tr>
<tr>
<td>Days</td>
<td>Calendar days unless otherwise specified.</td>
</tr>
<tr>
<td>Deliverables</td>
<td>Physical goods, services, and/or commodities as required or identified under the Contractor Requirements.</td>
</tr>
<tr>
<td>Dental Plan</td>
<td>A Dental vendor contracted with the State to provide or arrange for the delivery of Dental Services to Medicaid Enrollees that utilizes a managed care model, in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of Dental Services. A Dental Plan must have a Certificate of Authority from the State to provide oral health care services to Enrollees.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Care and procedures rendered by, or under the supervision of, Dentists for diagnosis or treatment of dental disease, injury or abnormality, based on valid dental need according to accepted standards of dental practice.</td>
</tr>
<tr>
<td>Dentist</td>
<td>A person licensed to practice dentistry in Michigan.</td>
</tr>
<tr>
<td>Department of Insurance and Financial Services (DIFS)</td>
<td>Responsible for oversight of insurers, Health Maintenance Organizations (HMOs), and financial entities doing business in the State.</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Federal mandate that provides comprehensive, preventive and Medically Necessary health care services for children under age 21 who are enrolled in Medicaid.</td>
</tr>
<tr>
<td>Electronic funds transfer (EFT)</td>
<td>Ability to electronically exchange funds between entities.</td>
</tr>
<tr>
<td>Electronic health record (EHR)</td>
<td>Ability to electronically exchange eligibility and claim information with Providers.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Emergency Dental Services</td>
<td>Care for an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or avulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>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.</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>Dental records containing detail for each enrollee encounter with a Provider for Dental Services for which Contractor paid Providers for Covered Services.</td>
</tr>
<tr>
<td>Enrollee</td>
<td>Any HKD Beneficiary who is currently enrolled in the Contractor's managed care Dental Plan.</td>
</tr>
<tr>
<td>Enrollment Services Contractor</td>
<td>An entity contracted with MDHHS to contact and educate HKD beneficiaries about managed care and to assist beneficiaries to enroll, dis-enroll, and change enrollment with their Contractor.</td>
</tr>
<tr>
<td>Expedited Appeal</td>
<td>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.</td>
</tr>
<tr>
<td>Expedited Authorization Decision</td>
<td>An authorization decision required to be expedited for cases which a provider indicates, or the Contractor determines, that following the standard timeframes 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. The Contractor may extend the 72 hour period by up to 14 calendar days if the Enrollee requests an extension, or if the Contractor justifies (to MDHHS) a need for additional information and how the extension is in the Enrollee's interest.</td>
</tr>
<tr>
<td>Expiration</td>
<td>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.</td>
</tr>
<tr>
<td>Explanation of Benefits (EOB)</td>
<td>Statement to covered individuals explaining the medical care or services that were paid for on their behalf.</td>
</tr>
<tr>
<td>External Quality Review (EQR)</td>
<td>Performance improvement goals, objectives and activities which are part of the Contractor's written plan for the Quality Assessment and Performance Improvement Program (QAPI).</td>
</tr>
<tr>
<td>External Quality Review Organization (EQRO)</td>
<td>Agency that provides EQR data analysis and assessment services.</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>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.</td>
</tr>
<tr>
<td>Fee-for-service (FFS)</td>
<td>A reimbursement methodology that provides a payment amount for each individual service delivered.</td>
</tr>
<tr>
<td>Fiscal Agent</td>
<td>An entity that manages fiscal matters on behalf of another party.</td>
</tr>
<tr>
<td>Fraud</td>
<td>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).</td>
</tr>
<tr>
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</tr>
<tr>
<td>Freedom of Information Act (FOIA)</td>
<td>Allows access by the general public to information held by governments or governmental entities.</td>
</tr>
<tr>
<td>Grievance</td>
<td>Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (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.</td>
</tr>
<tr>
<td>Health Equity</td>
<td>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.</td>
</tr>
<tr>
<td>Health Insurance Portability and Accountability Act (HIPAA)</td>
<td>The protection of medical records and information insuring any individual’s information is secure and only shared with others through their consent.</td>
</tr>
<tr>
<td>Healthcare Effectiveness Data and Information Set (HEDIS&lt;sup&gt;®&lt;/sup&gt;)</td>
<td>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.</td>
</tr>
<tr>
<td>Healthy Kids Dental (HKD)</td>
<td>Dental program administered by Contractor on behalf of the Department for Medicaid beneficiaries under the age of 21.</td>
</tr>
<tr>
<td>Indian Health Care Provider (IHCP)</td>
<td>A healthcare program operated by the Indian Health Service (IHS) 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)).</td>
</tr>
<tr>
<td>Initial Appointment</td>
<td>The first scheduled oral examination by a General Dentistry provider for a new patient admitted into the practice.</td>
</tr>
<tr>
<td>Initial Enrollment</td>
<td>First enrollment in Dental Plan following determination of eligibility; re-enrollment in a Dental Plan following a gap in eligibility of less than two month is not considered initial enrollment.</td>
</tr>
<tr>
<td>Licensing and Regulatory Affairs (LARA)</td>
<td>The State agency that is responsible for the State's regulatory environment and oversees licensing and regulation.</td>
</tr>
<tr>
<td>Marketing</td>
<td>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.</td>
</tr>
<tr>
<td>Marketing Materials</td>
<td>MDHHS must approve materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.</td>
</tr>
<tr>
<td>Medicaid</td>
<td>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.</td>
</tr>
<tr>
<td>Medicaid Health Plan (MHP)</td>
<td>Managed care organization that provides or arranges 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 an HMO.</td>
</tr>
<tr>
<td>Medical Necessity or Medically Necessary</td>
<td>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.</td>
</tr>
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</tr>
<tr>
<td>National Association of Insurance</td>
<td>The U.S standard-setting and regulatory support organization whose main responsibility is to protect the interests of insurance consumers.</td>
</tr>
<tr>
<td>Commissioners (NAIC)</td>
<td></td>
</tr>
<tr>
<td>National Committee for Quality Assurance</td>
<td>A private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.</td>
</tr>
<tr>
<td>(NCQA)</td>
<td></td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>A unique 10-digit identification number issued to health care providers in the United States by CMS.</td>
</tr>
<tr>
<td>Network Capacity</td>
<td>The number of Enrollees or Potential Enrollees that the Contractor can serve through its Provider Network under a Contract with the State. Network Capacity is determined by MDHHS in consultation with the Contractor based upon its Provider Network organizational capacity, available risk-based capital, and the Contractor’s ability to meet the Network adequacy and access to care standards and requirements in this Contract.</td>
</tr>
<tr>
<td>Oral Health Disparities</td>
<td>A particular type of oral health difference that is closely linked with social or economic disadvantage.</td>
</tr>
<tr>
<td>Oral Risk Assessment (ORA)</td>
<td>A tool developed by the American Dental Association to assess an individual's oral risk factors, protective factors and clinical findings related to dental caries adopted by MDHHS for HKD Beneficiaries.</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Covered Services rendered to a Beneficiary by a provider who is not part of the Contractor's Provider network.</td>
</tr>
<tr>
<td>Pediatric Specialist</td>
<td>A dental Pediatric Specialist is an age-defined specialist that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs licensed and certified by LARA.</td>
</tr>
<tr>
<td>Per Member Per Month (PMPM)</td>
<td>Capitated unit price payments to contracted primary care.</td>
</tr>
<tr>
<td>Periodicity Schedule</td>
<td>Guidelines for dental visits by age; the Department follows the American Academy of Pediatric Dentistry (AAPD) guidelines.</td>
</tr>
<tr>
<td>Physician Incentive Plan (PIP)</td>
<td>Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.</td>
</tr>
<tr>
<td>Population Health</td>
<td>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.</td>
</tr>
<tr>
<td>Potential Enrollee</td>
<td>HKD Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of a specific Contractor or other Managed Care Organization.</td>
</tr>
<tr>
<td>Prevalent Language</td>
<td>Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor’s Enrollees.</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Preventive Dental Services include services such as oral evaluations, routine cleanings, x-rays, sealants and fluoride treatments.</td>
</tr>
<tr>
<td>Provider (or Network Provider)</td>
<td>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 Enrollee .</td>
</tr>
<tr>
<td>Provider Contract</td>
<td>An agreement between the Contractor and a Provider for the provision of services under the Contract.</td>
</tr>
<tr>
<td>Provider Network</td>
<td>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.</td>
</tr>
<tr>
<td>Quality Assessment and Performance</td>
<td>An ongoing program for the services furnished to the Contractor’s Enrollees that meets the requirements of 42 CFR 438.240.</td>
</tr>
<tr>
<td>Improvement Program (QAPI)</td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>Quality Improvement Committee (QIC)</td>
<td>Committee of qualified professionals whose purpose is to continually measure quality and share those measures and results with each other to better able initiate process change and use “Evidence-based” practices to provide the best quality of care to patients served.</td>
</tr>
<tr>
<td>Recoupment</td>
<td>Any formal action by the State or its contractors to initiate recovery of an overpayment made to a Provider.</td>
</tr>
<tr>
<td>Routine Care</td>
<td>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 services such as fillings and space maintainers.</td>
</tr>
<tr>
<td>Rural</td>
<td>Rural is defined as any county not designated as metropolitan or outlying metropolitan by the Office of Management and Budget.</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>Public, non-profit or for-profit healthcare facility located in rural medically underserved areas. In Michigan, RHCs are certified by the Department of Licensing and Regulatory Affairs (LARA) to participate in Medicare and Medicaid programs under an agreement with CMS. The current RHCs in Michigan are listed as the following website: <a href="http://www.michigan.gov/documents/lara/MI_Rural_Health_Clinic_Directory_2-2016_515599_7.pdf">http://www.michigan.gov/documents/lara/MI_Rural_Health_Clinic_Directory_2-2016_515599_7.pdf</a>.</td>
</tr>
<tr>
<td>Social Determinants of Oral Health</td>
<td>The complex, integrated, and overlapping social structures and economic systems that are responsible for most oral health inequities. These social structures and economic systems include the social environment, physical environment, oral health and physical health services, and structural and societal factors. Social determinants of Oral health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.</td>
</tr>
<tr>
<td>Service Authorization Decision</td>
<td>Contractor's written response to Enrollee's Service Authorization Request provided as expeditiously as the Enrollee's condition requires and with 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) The Contractor justifies a need for additional information and how the extension is in the Enrollee's best interest.</td>
</tr>
<tr>
<td>Service Authorization Request</td>
<td>A managed care Enrollee's request for the provision of a service.</td>
</tr>
<tr>
<td>State</td>
<td>The State of Michigan, including any departments, divisions, agencies, offices, commissions, officers, employees, and agents.</td>
</tr>
<tr>
<td>State Fair Hearing</td>
<td>An impartial review by the State requested by a Medicaid Beneficiary of an adverse determination made by the Contractor held before an Administrative Law Judge through MDHHS' administrative hearing process.</td>
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<tr>
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<tr>
<td>Subcontract</td>
<td>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.</td>
</tr>
<tr>
<td>Subcontractor</td>
<td>Any person or entity that performs required, ongoing administrative or Benefit management functions for the Contractor.</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>Other dental insurance plan or carrier.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Services required to prevent serious deterioration of oral health following the onset of an unforeseen condition or injury.</td>
</tr>
<tr>
<td>Utilization Management (UM)</td>
<td>Oral health decisions relating to an individual's care.</td>
</tr>
<tr>
<td>Waste</td>
<td>The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.</td>
</tr>
</tbody>
</table>