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MEMBERS

(3.2) MEMBER HANDBOOK

Authority: 1.1XIII(E)(2)

MDHHS will review MHP's handbook on the website for contract requirements:

Information for all Members

1) 6.9 grade reading level
2) Culturally appropriate
3) Table of contents
4) Managed Care uniform definitions
5) How to access the provider directory, including any applicable web URL address
6) Advance Directives
7) Availability and process for accessing Covered Services that are not the responsibility of the Contractor, but are available to its Enrollees
8) Description of all available Contract Services
9) Copayment requirements
10) Rights to designate specialist as PCP
11) Enrollees' rights and responsibilities. Must include a statement that conveys that Contractor staff and affiliated Providers will comply with all requirements concerning Enrollee rights
12) Allow enrollees access to network or plan OB/GYNs and Pediatricians for routine services without a referral
13) Enrollee's right to receive FQHC and RHC services
14) Enrollees' right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
15) Enrollee's right to request information on the structure and operation of the Medicaid Health Plan
16) Explanation of any service limitations or exclusions from coverage
17) Explanation of counseling or referral services that the Medicaid Health Plan 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
18) Grievance, Appeal and Fair Hearing procedures and timeframes including how to file a Grievance with the Medicaid Health Plan and the internal Grievance resolution process
19) How Enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior
20) How to access hospice services
21) How to choose and change PCPs
22) How to contact the Contractor's Member Services and a description of its function
23) How to access out-of-county and out-of-state services
24) How to obtain emergency transportation
25) How to obtain non-emergent transportation covered under this Contract
26) How to obtain medically-necessary durable medical equipment (or customized durable medical equipment)
27) How to obtain oral interpretation services for all languages, not just prevalent languages

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28) How to obtain written materials in alternative formats for Enrollees with special needs
29) How to obtain written information in prevalent languages, as defined by the contract
30) How to access community-based supports and services in Enrollees' service area
31) Contractor's toll-free number for member services, medical management and the toll-free number Enrollees use to file a Grievance or Appeal and for any other unit providing services directly to Enrollees
32) Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant
33) Procedure for obtaining benefits, including any requirements for service authorizations and/or specialty care and for other benefits not furnished by the Enrollee's primary care provider
34) Signs of substance use problem, available substance use disorder services and accessing substance use disorder services
35) Vision services, family planning services, and how to access these services
36) Well-child care, immunization, and follow-up services for Enrollees under age 21 (EPSDT)
37) What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. The extent to which, and how, after hours and emergency coverage is provided, including: (1) what constitutes an emergency medical condition and emergency services, (2) the fact that prior authorization is not required for emergency services, and (3) the fact that Enrollee has a right to use any hospital or other setting for emergency care. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situation
38) What to do when family size changes
39) WIC Supplemental Food and Nutrition Program
40) Any other information deemed essential by the Medicaid Health Plan and/or MDHHS
41) 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
42) Restrictions, if any, on the Enrollee's freedom of choice among network providers
43) The extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from Out-of-Network Providers. This includes an explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider
44) Information on how to report suspected Fraud or Abuse
45) Information on how to access continued services upon transition to health plan.
46) Information on the availability of telehealth/telemedicine, where applicable
47) Information on MIHP and how to access

Information for Healthy Michigan Plan Members

48) HMP enrollees provided habilitative services
49) HMP enrollees provided dental services

Submit: **June 15th**

50) Evidence that beneficiary requests for printed handbooks are processed within 5 business days

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(3.3) MEMBER NEWSLETTERS

Authority: 1.1XIII(C)(1)(b)

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MDHHS will review MHP's website to ensure member newsletter meets the requirements of the contract:

1) 6.9 reading grade level
2) Culturally appropriate
3) Distributed at least twice per year

(3.4) WEBSITE IS MAINTAINED AND REVIEWED

Authority: 1.1XIII(C)(1)(d); (E)(2); VIV(A)(9)

MDHHS will review MHP's website to ensure it contains appropriate content:

1) Information on how to contact the health plan
2) Preventative health information
3) Health and wellness programs
4) Updates on covered services
5) Provider directory
6) Grievance and appeal information
7) MCO common drug formulary
8) Member handbook
9) Provider appeal information
10) Claims process

QUALITY

(4.10) ADDRESSING HEALTH DISPARITIES – POPULATION HEALTH MGMT (PHM)

Authority: 1.1X(B)(1)(b)

Submit *Policies/Procedure for providing population health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following areas: (If MHP passed these items in the last compliance review, and the contracts have not changed, an attestation that the contract includes the required content will be acceptable. Any item not passed in the last compliance review must be submitted.)*

1) Adult and family shelter for Enrollees who are homeless
2) The Enrollee's home
3) The Enrollee's place of employment or school

MAY 15, 2020

(5.5) THIRD PARTY RECOVERY QUARTERLY REPORT

Authority: 1.1XVII(G)(7)

*Complete and **submit** Third Party Recovery report for **FY2020 Q2 January 1, 2020 through March 31, 2020** to the TPL FTP site*

OIG

(6.1), (6.2), (6.3), (6.4), (6.5) (6.6) PROGRAM INTEGRITY

Authority: 1.1XVIII(G, H)

*Complete and **submit** Program Integrity form and related reports for **Reporting Period of January 1, 2020 through March 31, 2020:***

1) Tips and Grievances
2) Data Mining
3) Audits
4) Provider Dis-enrollments
5) Overpayments Collected
6) EOB Reporting Requirements

JUNE 15, 2020

PROVIDERS

(2.6) MHP PROVIDER DIRECTORY

Authority: 1.1XIII (F)

MDHHS will conduct secret shopper calls of a sample of open PCPs listed in the on-line MHP Provider Directory (same PCPs called in October & February) to check for provider availability accuracy as well as contact/address information accuracy. In calculating percentages, PCPs accepting all new patients will count as 1 point, PCPs who have conditions on who they will accept as new patients will count as ½ point (if the conditional status is not indicated in the Provider Directory). Item will be scored as Pass or Fail. Passing is at least 75% of the sample for:

1) PCPs who are listed as accepting new patients and confirm this during the call
2) PCPs who have matching phone number/address information in the MHP Provider Directory as confirmed during the call or found on the 4275 submitted to MAXIMUS.

MEMBERS

(3.1) MEMBER MATERIAL – ID CARD AND MEMBER HANDBOOK

Authority: 1.1XIII(E)(1)

MEMBER MATERIAL: ID CARD AND MEMBER HANDBOOK MUST BE MAILED WITHIN 10 BUSINESS DAYS OF NOTIFICATION OF ENROLLMENT

Submit *a 12-month report (CY 2019) broken down by month documenting ID cards mailed 1st class within 10 business days and Member Handbook mailed within 10 business days of notification of enrollment. The report should include* ***at a minimum*** *the date the enrollment file was available, the date of the mailings including member ID cards and member packets, if mailed separately, whether the mailings were 1st class or 3rd class, and the number of ID cards, member packets and members in each month.* ***Submit*** *a copy of health plan ID card which includes Medicaid ID number.*

1) ID cards mailed 1st class (submit report demonstrating the 10 days' mailing requirement)
2) Copy of health plan ID card which includes Medicaid ID number
3) New member packets, including member handbook are mailed (submit report demonstrating the 10 days' mailing requirement)

(3.2) MEMBER HANDBOOK

Authority: 1.1XIII(E)(2)

Submit: **Moved from April, was number 50**

1) Evidence that beneficiary requests for printed handbooks are processed within 5 business days

JUNE 15, 2020

(3.12) PREGNANT WOMEN DENTAL POLICIES AND PROCEDURES

Authority: 1.1IV(O)

Submit *policies and procedures related to pregnant women dental eligibility and services.*

QUALITY

(4.3) QIP EVALUATION AND WORK PLAN; UM PROGRAM AND EFFECTIVENESS REVIEW

Authority: 1.1XI(A, B); 3.2II(B)

Submit *the following approved Quality Improvement documents with approval dates:*

1) Current year program description
2) Current year work plan
3) Previous year program evaluation
4) Annual Quality Program worksheet completed. **Must include highlights, document names and page numbers as required**

Submit *the following approved Utilization Review documents:*

5) Current year program description which includes: Approval dates; Highlighted changed since last submission
6) Previous year effectiveness review/evaluation

(4.4) QI & UM POLICIES/PROCEDURES

Authority: 1.1XI(I)

Submit *final approved QI & UM policies and procedures (if new or changed) OR provide narrative attestation if no changes have occurred.*

1) Provide page reference and highlight changes since last submission
2) Include policy and procedure language which gives management authority to the Medical Director

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MIS

(5.1) MIS HEALTH PLAN MAINTAINS AN INFORMATION SYSTEM THAT COLLECTS, ANALYZES, INTEGRATES AND REPORTS DATA AS REQUIRED BY MDHHS

Authority: 1.1XI(H); XV(A); V(A)

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Submit *Operational plan and screen prints, if applicable, demonstrating: (If changes, otherwise provide narrative attestation)*

1) Member enrollment and disenrollment
2) Provider enrollment
3) Third party liability activity
4) Claims payment
5) Grievance and Appeals tracking
6) Encounter reporting
7) Assignment to PCP within one month if member does not choose a PCP at the time of enrollment
8) Quality report such as tracking and recall for EPSDT service and immunization reporting, enrollee access and satisfaction
9) Appropriate use of CC360: designate 1 Super Managing Employee (SuME) and at least one Managing Employee

For HMP Enrollees Only: ***Submit*** *operational plan and screen prints, if applicable, demonstrating:*

10) Collection and tracking of HMP enrollee-specific Health Risk Assessment information, provided in the MDHHS specified format
11) Collection and tracking HMP enrollee-specific healthy behavior and goal information for MHP enrollees, provided in the MDHHS specified format

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(5.2) HEALTH PLAN HAS A WRITTEN PROCEDURE TO ELECTRONICALLY PROCESS ENROLLMENTS AND DIS-ENROLLMENTS

Authority: 1.1XV(B)

Submit *written procedure to electronically process enrollments and dis-enrollments and submit screen prints showing: (If changes, otherwise provide narrative attestation)*

1) Reconciling of enrollment files
2) Name
3) Address
4) Phone number
5) Parents
6) Gender
7) Language spoken
8) Race/Ethnicity
9) Guardian

For HMP Enrollees only: ***Submit*** *screen prints showing:*

10) Enrollee income
11) Income/Group composition
12) Federal poverty level

(5.3) AUDITED FINANCIAL STATEMENT

Authority: 3.2II(C)

Submit *:*

1) Audited Financial Statement

MIS

(5.3) MANAGEMENT DISCUSSION AND ANALYSIS

Authority: 3.2II(J)

Submit:

1) Management Discussion and Analysis

(5.6) PHARMACY/MCO COMMON FORMULARY

Authority: 1.1 VI(D)

Submit *all paid/denied/rejected/reversed claims for the time periods of* ***10/01/19-10/08/19*** *and* ***01/01/20-01/08/20****.*

1) Accurate NCPDP 831 Rejections
    a) Must have NCPDP 831 rejection coding set as the primary rejection for carve-out claim
    b) Must have less than 0.5% noncompliant claims
2) Accurate NCPDP 70 Rejections
    a) Must have less than 0.1% noncompliant claims for products covered on the Common Formulary
3) Must have non-controlled refill thresholds set at no greater than 75%

OIG

(6.7) OIG PROGRAM INTEGRITY – FRAUD COMPLIANCE PROGRAM

Authority: 1.1VXIII(A); 42CFR§438.608

Fraud Compliance Program

1) ***Submit*** a compliance plan and additional documentation considered to be proof of administrative and management arrangements or procedures designated to detect and prevent fraud, waste and abuse

Arrangements or procedures must include the following:

2) Policies and procedures, administrative arrangements, standards of conduct, and any additional documentation that supports commitment to comply with Program Integrity requirements
3) Documentation that support compliance officer, compliance committee, and SIU roles in the organization

a) Organization chart(s) displaying:
   i. Compliance Officer who reports directly to the Chief Executive Officer and the Board of Directors
   ii. Regulatory Compliance Committee that sits at the MHP level or the corporate level
   iii. Special Investigations separate from compliance, utilization review and quality of care function
      A. Part of the MHP corporate structure, OR
      B. Operates under contract with the MHP

4) Documentation of employee education and any associated testing on preventing, recognizing, and reporting FWA. In addition to employee training materials, FWA education materials made available to provider and members (e.g., bulletins, newsletters, or blast-faxes) must be supplied to gauge availability and accuracy
   a) Program Integrity and/or FWA Training/Education for:
      i. Senior Management
      ii. Compliance Officer
      iii. Employees
   b) Communication of compliance officer contact information to employees
   c) Communication of FWA reporting processes to employees
   d) Documentation of policies and procedures relating to annual review and revision of employee education and training materials
5) Documentation of guidelines for:
   a) Communication between compliance officer, compliance committee, and employees
   b) Communication between SIU and law enforcement, MDHHS OIG, and other entities, including provider and members. Also includes coordination of investigation of suspected criminal act with law enforcement agencies
   c) Documentation of meeting/training sessions conducted by compliance officer and/or compliance committee concerning FWA
   d) Documentation of providing MDHHS OIG contact information to employees, providers, and members on an annual basis (within the past year)
6) Documentation of formal policies and procedures that address internal process for investigating, tracking, and closing complaints relating to compliance. Documentation of formal compliance infractions and subsequent penalties, including corrective action plan procedures
7) Documentation of policies and procedures for internal monitoring of member utilization and provider billing practices:
   a) Documentation of advanced system edits to identify potential FWA before a claim is paid
   b) Documentation of the review process that gauges effectiveness of system edits
   c) Documentation of software and/or monitoring systems (or vendors) relating to the detection of FWA after adjudication
8) Documentation of SIU/auditing practices, including:
   a) FWA complaint/case intake, including any forms and/or methods used to capture employee, provider, and member grievances and/or complaints
   b) Substantiation of a complaint/case
   c) Documentation of audit/investigation policies and procedures
9) Documentation of audit/investigation closure and response to findings
   a) Documentation of formal corrective action processes relating to members and providers
   b) Documentation of overpayment collection policies and procedures, including the appeal rights and adjustment of encounter claims

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10) Documentation of policy and process to verify services billed by providers were received by members, including verification that excluded services are included in the process
11) Documentation of credentialing, termination, and payment suspension practices:
    a) Documentation of policies and procedures for screening affiliates, employees, and owners or controlling interests for criminal convictions and exclusion from Medicaid, Medicare, or any other federally subsidized program the MHP services
    b) Documentation of procedures for terminating a provider after notification of exclusion (HHS), summary suspension (MDHHS OIG), or loss/restriction of license (LARA)
    c) Documentation of policy for suspending payment to a provider up on notification by HHS or MDHHS

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OIG

(6.8) OIG PROGRAM INTEGRITY

Authority: 1.1VIII(B); 42 CFR§438.606; 42 CFR§438.608

Submit *Annual Program Integrity Report for* ***FY19 for the dates of October 1, 2018 – September 30, 2019***

1) Including quarterly submission from February **2019**, May **2019**, August **2019** and November **2019**
2) Certified by MHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification
3) Certification must attest that, based on best information, knowledge and belief, the information specified is accurate, complete and truthful
4) Compare the report to the plan submitted for FY19 and in the report explain inconsistencies between the plan and the report as applicable

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(6.9) OIG PROGRAM INTEGRITY

Authority: 1.1VIII(B)

Submit

1) *Annual Program Integrity Plan for* ***FY20 to include date from October 1, 2020 – September 30, 2021***

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MEMBERS

(3.5) MEMBER GRIEVANCES AND APPEAL RESOLUTION

Authority: 1.1XIII(G)

Submit *GAP enrollee letter template: (If MHP passed these items in the last compliance review, and the contracts have not changed, an attestation that the contract includes the required content will be acceptable. Any item not passed in the last compliance review must be submitted.)*

1) Must acknowledge receipt of each grievance and appeal
2) Ensure that individuals who make decisions on grievances and appeals were not involved in the previous level of decision making and have clinical expertise when an appeal involves a clinical issue
3) Must advise enrollee of their right to a Fair Hearing with the State of Michigan
4) Written authorization from the member for the provider to act on behalf of the member for non-expedited grievance and appeals
5) Provisions for enrollee benefits to continue pending resolution of the appeal
6) Explanation of the appeal process

Submit *policies for Grievance and Appeals. Policies and Procedures must: (If MHP passed these items in the last compliance review, and the contracts have not changed, an attestation that the contract includes the required content will be acceptable. Any item not passed in the last compliance review must be submitted.)*

1) Include that appeal and grievance notices are available in the prevalent non-English languages in its Service Area
2) Confirms it uses only MDHHS approved materials and information relating to Grievances and Appeals
3) Appeal and fair hearing procedures and timeframes including:
    a) Contractor must allow Enrollees 60 days from the date of the Adverse Benefit notice in which to file an Appeal
    b) Contractor must make a determination on non-expedited Appeals no later than 30 days after an Appeal is submitted in writing by the Enrollee
    c) Contractor must make a determination on Grievances within 90 days of the submission of the Grievance
4) Ensure availability of assistance in the filing process
5) Explain 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
6) Explain, when requested by the Enrollee, benefits that the MHP 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
7) Include only one level of Appeal for Enrollees. Ensure MHP provides the Enrollee with Grievance, Appeal and Fair Hearing procedures and timeframes to all Providers and Subcontractors at the time they enter into a contract

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(3.6) WRITTEN MEMBER APPEAL DECISIONS RENDERED

Authority: 1.1XIII(G); 3.2 II(G)

Submit *Member Grievance and Appeal Log (**April 2019-March 2020**) separated into the four benefit plans: MA-MC; HMP-MC; MME-MC; CSHCS-MC*

1) 30 calendar days for a non-expedited appeal. Health plan's decision may be extended for an additional 10 business days if the health plan has not received requested information, if it benefits the enrollee
2) 72 hours from receipt for an expedited appeal
3) Transportation issues (must be highlighted/easy to sort out)
4) Rate of grievance and appeals for CSHCS enrollees for **April 2019-March 2020** (# of grievance and appeals over total # of CSHCS enrollees in MHP)
5) Rate of PA appeals for CSHCS enrollees for **April 2019-March 2020** (# of PA appeals over total # of CSHCS enrollees in MHP)
6) Log submission

(3.8) CSHCS COLLABORATION

Authority: 1.1V(N)

Submit *policies and procedures related to collaboration with Local Health Departments (LHDs) to coordinate care for CSHCS Enrollees. Policies/procedures should address: (If MHP passed these items in the last compliance review, and the contracts have not changed, an attestation that the contract includes the required content will be acceptable. Any item not passed in the last compliance review must be submitted.)*

1) Communication on development of Care Coordination Plans
2) Quality assurance coordination
3) Care planning for Enrollees transitioning into adulthood
4) Utilization of an electronic system by which providers and other entities can send and receive client level information for the purpose of care management and coordination
5) Sharing Enrollee information with LHD to coordinate care without specific agreements
6) How the MHP assesses the need for a care manager and family-centered care plan developed in conjunction with the family and care team
7) That Enrollees and families have the opportunity to provide input on Contractor policies and procedures that influence access to medical services or member services
8) Information about Children's Multidisciplinary Specialty (CMDS) Clinics

Web Review:

9) Must include educational content and outreach information specifically directed to CSHCS Enrollees with a mechanism for CSHCS Enrollee and family to contact specially-trained staff to assist them

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(3.9) PCP SELECTION POLICIES & PROCEDURES

Authority: 1.1V(E)

Submit *policies and procedures describing how members choose a PCP, are assigned to a PCP, and how they may change their PCP. Must include:*

1) Providing members the opportunity to change their PCP regardless of whether the PCP was chosen by the member or assigned by the MHP
2) Members may change PCP by telephone or written notification (web based is allowed)
3) No restrictions on the number of times a member can change PCPs with cause

4) Implements member PCP assignment within five business days of receipt of member's PCP selected request.
5) Any policy that restricts the member's ability to change PCPs without cause was approved by MDHHS prior to implementation
6) MHP reports PCP selections, changes, deletions to MDHHS on 5284 files within 10 business days of changes

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(3.10) CSHCS PCP REQUIREMENTS

Authority: 1.1V(F)

Submit *policies and procedures describing how CSHCS members are assigned a PCP. Must include:*

1) CSHCS Enrollees are assigned to CSHCS-attested PCP practices that provide family-centered care.
2) MHP obtains a written attestation from PCPs willing to serve CSHCS Enrollees that specifies the PCP/practice meets the following qualifications:
    a) Is willing to accept new CSHCS Enrollees with potentially complex health conditions
    b) Regularly serves children or youth with complex chronic health conditions
    c) Has a mechanism to identify children/youth with chronic health conditions
    d) Provides expanded appointments when children have complex needs and require more time
    e) Has experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
    f) Has a designated professional responsible for care coordination for children who see multiple professionals
    g) Provides services appropriate for youth transitioning into adulthood, including but not limited to; the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies:
        i. the transition time frame
        ii. transition approach
        iii. legal changes that take place in privacy and consent at age 18
3) MHP maintains a roster of Providers who meet the criteria listed above and can serve CSHCS Enrollees.

QUALITY

(4.5) HEDIS IDSS

Authority: 3.2II(D)

Submit *the following HEDIS materials (Refer to annual HEDIS letter from MDHHS for instructions)*

1) Audited IDSS in electronic format which includes: ART, CSV and data-filled workbook
2) Copy of signed and dated attestation of accuracy and public reporting authorization – Medicaid letter

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(4.7) PERFORMANCE IMPROVEMENT PROJECTS (MHP-INITIATED PIPS)

Authority: 1.1XI(C)

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Submit *documentation for all MHP initiated PIPs (do NOT include EQRO PIP documents)*

(4.16) COMMUNITY HEALTH WORKER (CHW) RATIO

Authority: 1.1 VIII(B)

Submit *template provided by MDHHS demonstrating adherence CHW ratio requirement. MHP must maintain a CHW to enrollee ratio of one full-time CHW per 7,500 Enrollees not later than July 1, 2020.*

MIS

(5.3) QUARTERLY FINANCIALS

Authority: 3.2II(A), Appendix 3

1) ***Submit*** *Quarterly Financial Statements and Reports that were submitted to DIFS* ***for FY2020 Q2: January 1, 2020 through March 31, 2020***
    a) Quarterly Statement
    b) Risk Based Capital
    c) Statement of Actuarial Opinion
    d) FIS 317 – Revenue and Expense Report for HMOs
    e) FIS 320 – HMO Inpatient Discharges & Benefits Payout Report
    f) FIS 321 – Working Capital Calculation
    g) Third Party Collections

(5.4) THIRD PARTY LIABILITY RECOVERY POLICIES AND PROCEDURES

Authority: 1.1XVII(G)

Submit *policies and procedures describing TPL recovery. Policies must include:*

1) MHP seeks to identify and recover all sources of third-party funds based on industry standards and those outlined by MDHHS TPL Division.
2) MHP follows Medicaid Policy, guidance and all applicable state and federal statutes regarding TPL.
3) P&P are consistent with TPL recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.
4) MHP collects any payments available from other health insurers including Medicare and private health insurance in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D.
5) When MHP denies a claim due to third party resources, the MHP provides the other insurance carrier ID, if known, to the billing provider.
6) MHP responds within 30 days of subrogation notification pursuant to MCL 400.106 (10).

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(6.10) OIG PROGRAM INTEGRITY

Authority: 1.1XVIII(F); 42CFR§438.610

MHP and Provider Enrollment, Screening and Disclosure Requirements

1) Complete applicable attestation form

AUGUST 15, 2020

ADMINISTRATIVE

(1.3) GOVERNING BODY

Authority: 2.1III

Submit:

1) List of Board Members with term length
2) Board meeting dates
3) Board meeting minutes **(Will be reviewed on-site – do not submit)**
4) Board Member appointment policy

(1.4) MANDATORY ADMINISTRATIVE MEETINGS

Authority: 3.1 I(A)

MDHHS will track contractor or contractor representative attendance at the following meetings

1) Bi-Monthly Administrative Issues (Bi-monthly)
2) Clinical Advisory Committee (Quarterly)
3) CEO (Bi-monthly)
4) Operations (Bi-Weekly)
5) QI Directors (Bi-monthly)
6) Other meetings as directed by MDHHS

(1.5) DATA PRIVACY & INFORMATION SECURITY

Authority: Standard Contract Terms, 24b

1) ***Submit*** annual audit findings from comprehensive independent third-party audit of data privacy and information security program

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QUALITY

(2.12) MATERNAL INFANT HEALTH PROGRAM (MIHP) ACTIVITIES

Authority: 1.1VI(N)

Submit *a narrative with page numbers and document names for items references below (a-i)* ***Submit*** *annual report on MIHP activities, including:*

1) Provide a summary and template(s) of executed agreements. Only include the template if it is different than the DHHS format. Agreements must include:
    a) Medical coordination, including pharmacy and laboratory coordination
    b) Data and reporting requirements
    c) Quality assurance coordination

d) Grievance and Appeal resolution
e) Dispute resolution
f) Transportation
g) Enrollee referral MIHP Provider organization within 30 days of MIHP eligibility determination, if the Enrollee is not already enrolled in another evidenced based home-visiting program
h) Sufficient number of MIHP Providers to meet Enrollee service and visitation needs within the required response time according to MDHHS MIHP protocols
i) Service delivery response times

2) Specific examples of collaborative approaches and program success
3) Summary of quality improvement initiatives
4) Send dates of MIHP regularly scheduled meetings including locations and agendas
5) Policies and procedures related to referring to behavioral health and out-of-network

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(2.14) DENTAL PROVIDER DIRECTORY REPORT

Authority: Appendix 14 & 15

Submit *Provider Directory Template (provided by MDHHS). Template will include provider directory and access ratios.*

PROVIDERS

(2.16) PBM SERVICE ORGANZIATION CONTROLS REPORT (SOC-1)

Authority: 1.1VI(D)(20)(d)(1)

Submit copy of Service Organization Controls report (SOC-1) audit of the PBM's services and activities.

MEMBERS

(3.13) CSHCS CONSULTATION

Authority: 1.1X(D)(1)(G)

MDHHS Review. Complete two (2) CSHCS consultation calls with MDHHS prior to August. MHP must submit information as requested and specified by Office of Medical Affairs staff and as outlined below.

1) Office of Medical Affairs will schedule a telephone conference twice per year with a MDHHS CSHCS Medical Consultant and the Medical Director and nurse reviewer of the health plan.
2) Six weeks prior to the meeting, the CSHCS Medical Consultant will request cases (approx. 4 or 5) from the health plan to conduct an initial review.
3) Three weeks prior to the meeting, the health plan will provide their cases electronically via MCPD FTP.

AUGUST 15, 2020

QUALITY

(4.6) HEDIS FINANCIAL AUDIT REPORT (FAR)

Authority: 3.2 II(D)

Submit *HEDIS Final Audit Report (refer to annual HEDIS letter from MDHHS for instructions)*

1) A copy of the MHP's NCQA-certified HEDIS compliance auditor's signed and dated Final Audit Opinion and report

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(4.9) PMR REVIEW

Authority: 1.1XI(D)

Review of the most current, ***published****, PMR*

1) Reviewing the most current published PMR rates, as compared to established MDHHS standards
2) Acceptable CAPs received for measures that did not meet the standard

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(4.12) TOBACCO CESSATION

Authority: 1.1VI(G)

Submit *the Medicaid Tobacco Cessation Benefits Grid as provided by MDHHS detailing tobacco cessation treatment that includes, at a minimum, the following services:*

1) Approved telephone quit line
2) Individual counseling separate from the 20 outpatient visits
3) Prescription inhaler
4) Nasal spray
5) Non-nicotine prescription medication
6) OTC agents: patch, gum, lozenge
7) Combination therapy

(4.13) FAMILY PLANNING GRID

Authority: 1.2V(G)

Submit *the Family Planning Grid as provided by MDHHS detailing family planning services that include, at minimum, the following:*

1) Ensure that enrollees have full freedom of choice of family planning providers, both in-network and out-of-network
2) Allow enrollees to seek family planning services, drugs, supplies and devices without prior authorization
3) Regarding type, duration, or frequency of drugs, supplies and devices for the purpose of family planning, be not more restrictive than Medicaid FFS

4) Maintain accessibility and confidentiality for family planning services

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(4.14) MI HEALTH ACCOUNT VENDOR OVERSIGHT

Authority: XII(B)

Submit *a description of ongoing monitoring of MI Health Account Vendor which must include:*

1) Review of all Maximus required reports
2) Participate in all quarterly oversight meetings with MI Health Account Vendor and description of processes to follow-up on issues identified during the course of oversight
3) Description of monitoring related to member education on cost-sharing responsibilities including welcome letter, statements, and payment coupons

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(4.15) MEMBER INCENTIVE

Authority:

Submit *Policy/Program Description that outlines the MHP process for members receiving an incentive. This includes, at minimum, the following:*

1) Method of receiving and processing completed Health Risk Assessments and identifying which members are eligible for incentives, including:
    a) HRAs completed during the FFS period, and
    b) Second and subsequent year HRAs
2) Process to 'flag' those members for an incentive in the MIS/administrative system
3) Process for identifying member who have identified health risk reduction goals on HRA and outreach to these members. Report of members reached and documentation of support services, education, or other interventions provided by MHP
4) Process for outreach and education on the completion of second and subsequent year HRAs
5) Description of updates to all policies/procedures related to revisions to HMP Health Risk Assessment and new Healthy Behaviors Incentives
6) Weekly submission of the 5944 Healthy Behaviors file

QUALITY

(4.17) DENTAL DATA EXTRACT

Authority: 1.1X(A)(2)(a)

Submit *denta data as outlined in the data extract specifications provided by MDHHS. Template will be provided*

AUGUST 15, 2020

(4.18) ORAL HEALTH QUALITY – QIP EVALUATION AND WORK PLAN FOR ORAL HEALTH; UM PROGRAM AND EFFECTIVENESS REVIEW

Authority: 1.1X(A, B); 3.2II(B)

Submit *the following approved Quality Improvement documents with approval dates:*

1) *Current year program description*
2) *Current year work plan*
3) *Annual Quality Program worksheet completed. Must include highlights, document names and page numbers as required*

Submit *the following approved Utilization Review documents:*

4) *Current year program description which includes: Approval dates and highlighted changes since last submission*

(4.19) ORAL HEALTH QUALITY – QI & UM POLICIES AND PROCEDURES

Authority: 1.1XI(I)

Submit *final approved QI & UM policies and procedures:*

1) *Provide page reference and highlight changes since last submission*
2) *Include policy and procedure language which gives management authority to the Medical Director*

MIS

(5.3) QUARTERLY FINANCIALS

Authority: 3.2 II(A), Appendix 3

1) ***Submit*** *Quarterly Financial Statements and Reports that were submitted to DIFS* ***FY2020 Q3 April 1, 2020 through June 30, 2020***
    a) Quarterly Statement
    b) Risk Based Capital
    c) Statement of Actuarial Opinion
    d) FIS 317 – Revenue and Expense Report for HMOs
    e) FIS 320 – HMO Inpatient Discharges & Benefits Payout Report
    f) FIS 321 – Working Capital Calculation
    g) Third Party Collections

(5.5) THIRD PARTY RECOVERY QUARTERLY REPORT

Authority: 1.1XVII(G)(7)

AUGUST 15, 2020

*Complete and **submit** Third Party Recovery report for **FY2020 Q3 April 1, 2020 through June 30, 2020** to the TPL FTP site.*

(5.7) THIRD PARTY WEEKLY MATCH REPORTS

Authority: 1.1 XVII (G)(8)

***MDHHS Review** of downloads of TPL Weekly Match Reports. MHPs must be downloading the reports monthly at a minimum.*

OIG

(6.1) (6.2) (6.3) (6.4) (6.5) (6.6) PROGRAM INTEGRITY

Authority: 1.1XVIII (H)

*Complete and **submit** Program Integrity form and related reports for **FY2020 Q3 April 1, 2020 through June 30, 2020***

1) Tips and Grievances
2) Data Mining
3) Audits
4) Provider Dis-enrollments
5) Overpayments Collected
6) EOB Reporting Requirements
