STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
525 W. ALLEGAN ST., LANSING, MICHIGAN 48913
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **2**

to

Contract Number **071B5500060**

CONTRACTOR	
	MICHIGAN PEER REVIEW ORGANIZATION
	22670 Haggerty Road
	Farmington Hills, MI 48335
	Leland Babitch
	248-465-7400
	lbabitch@mpro.org
	CV0029952

STATE			
	Program Manager	Michelle Mapes	MDHHS
		517-335-5572	
		mapesm@michigan.gov	
	Contract Administrator	Brandon Samuel	DTMB
		(517) 249-0439	
		samuelb@michigan.gov	

CONTRACT SUMMARY

REVIEW AND CERTIFICATION OF INPATIENT (PACER) ADMISSIONS, SELECTED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES, VENTILATOR DEPENDENT CARE UNIT ADMISSIONS AND CONTINUED STAYS AND NURSING FACILITY LEVEL OF CARE– MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
January 1, 2015	December 31, 2017	2 - 1 Year	December 31, 2018

PAYMENT TERMS	DELIVERY TIMEFRAME
1NET10 and NET45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	12 months	☐		December 31, 2019

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$5,824,175.00	$0.00	$5,824,175.00

DESCRIPTION

Effective December 15, 2018, the second option year available on this contract is hereby exercised. The revised expiration date is December 31, 2019.

STATE OF MICHIGAN
ENTERPRISE PROCUREMENT
Department of Technology, Management, and Budget
525 W. ALLEGAN ST., LANSING, MICHIGAN 48913
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **1**

to

Contract Number **071B5500060**

CONTRACTOR	
	MICHIGAN PEER REVIEW ORGANIZATION
	22670 Haggerty Road
	Farmington Hills, MI 48335
	Leland Babitch
	248-465-7400
	lbabitch@mpro.org
	*******6610

STATE			
	Program Manager	Michelle Mapes	MDHHS
		517-335-5572	
		mapesm@michigan.gov	
	Contract Administrator	Brandon Samuel	DTMB
		(517) 284-7025	
		samuelb@michigan.gov	

CONTRACT SUMMARY

REVIEW AND CERTIFICATION OF INPATIENT (PACER) ADMISSIONS, SELECTED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES, VENTILATOR DEPENDENT CARE UNIT ADMISSIONS AND CONTINUED STAYS AND NURSING FACILITY LEVEL OF CARE– MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2015	December 31, 2017	2 - 1 Year	December 31, 2017

PAYMENT TERMS	DELIVERY TIMEFRAME
	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	12 months	☐	N/A	December 31, 2018

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$4,368,131.25	$1,456,043.75	$5,824,175.00

DESCRIPTION

Effective November 15, 2017, please note the following changes:

1.) The first option year available on this contract is hereby exercised. The revised contract expiration date is 12/31/2018.

2.) This contract is hereby increased by $1,456,043.75.

3.) Please note the Contractor has been change to Leland Babitch: Phone: 248-465-7400, Email: Lbabitch@mpro.org.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on November 14, 2017.

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

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

NOTICE OF CONTRACT NO. 071B5500060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611	Robert J. Yellan, JD, MPH	ryellan@mpro.org
	TELEPHONE	**CONTRACTOR #, MAIL CODE**
	248-465-7400	001

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER:	Community Health	Michelle Mapes and Elizabeth Aastad	517-335-5572 and 517-241-2115	mapesm@michigan.gov and Aastade@michigan.gov
BUYER:	Technology, Management & Budget	Lance Kingsbury	517-284-7017	KingsburyL@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION:

Review and Certification of Inpatient (PACER) Admissions, Selected Durable Medical Equipment and Medical Supplies, Ventilator Dependent Care Unit Admissions and Continued Stays and Nursing Facility Level of Care– Michigan Department of Community Health

INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
3 Years	January 1, 2015	December 31, 2017	2, 1-Year Renewals
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
1NET10 and NET45	Destination	N/A	N/A

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

MINIMUM DELIVERY REQUIREMENTS:

N/A

MISCELLANEOUS INFORMATION:

N/A

ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION:	**$4,368,131.25**

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the solicitation #007115B0003331. Orders for delivery will be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

Form No. DTMB-3522 (Rev. 4/2012)

Notice of Contract #: 071B5500060

FOR THE CONTRACTOR:	FOR THE STATE:
Michigan Peer Review Organization	
Firm Name	Signature
	Tom Falik, Services Director
Authorized Agent Signature	Name/Title
	DTMB Procurement
Authorized Agent (Print or Type)	Enter Name of Agency
	12-31-14
Date	Date

STATE OF MICHIGAN

STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and awarded Michigan Peer Review Organization ("**Contractor**"), a Michigan corporation. This Contract is effective on January 1, 2015 ("**Effective Date**"), and unless terminated, expires on December 31, 2017.

This Contract may be renewed for up to two, one-year renewal Options. Renewal must be by written agreement of the parties.

The parties agree as follows:

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

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

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

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

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

If to State:	If to Contractor:
Lance Kingsbury, Buyer 525 West Allegan, 1st Floor Lansing, MI 48933 517-284-7017 kingsburyl@michigan.gov	Robert J. Yellan, 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 (248) 465-7400 (Phone) (248) 465-7430 (Fax) ryellan@mpro.org

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

If to State:	If to Contractor:
Lance Kingsbury, Buyer 525 West Allegan, 1st Floor Lansing, MI 48933 517-284-7017 kingsburyl@michigan.gov	Robert J. Yellan, 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 (248) 465-7400 (Phone) (248) 465-7430 (Fax) ryellan@mpro.org

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**"):

If to State:	If to Contractor:
Michelle Mapes, Inpatient PACER, MDCH Selected DME/Medical Supply and Ventilator Dependent Care Unit Contract Manager Michigan Department of Community Health 400 S. Pine St. – 6th Floor Lansing, MI 48909 mapesm@michigan.gov 517-335-5572	Melody Petrul, RN
Elizabeth Aastad, Long Term Care Contract Manager Michigan Department of Community Health 400 S. Pine St. – 7th Floor Lansing MI 48909 Aastade@michigan.gov 517-241-2115	Yvonne Kendall, RN

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

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

Insurance Type	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence Limit $1,000,000 Personal & Advertising Injury Limit $2,000,000 General Aggregate Limit $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Each Occurrence	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 04; (2) include a waiver of subrogation; and (3) for a claims-made policy, provide three years of tail coverage.
Umbrella or Excess Liability Insurance	
Minimal Limits: $5,000,000 General Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices,

	commissions, officers, employees, and agents" as additional insureds, and (2) include a waiver of subrogation.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $100,000 Each Accident $100,000 Each Employee by Disease $500,000 Aggregate Disease.	
Cyber Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

If Contractor's policy contains limits higher than the minimum limits, the State is entitled to coverage to the extent of the higher limits. The minimum limits are not intended, and may not be construed to limit any liability or indemnity of Contractor to any indemnified party or other persons.

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 5 business days if any insurance is cancelled; and (d) waive all rights against the State for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

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.

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.

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, provide all necessary documentation and signatures, and continue to perform, with the third party, its obligations under the Contract.

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 Exhibit 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 Exhibit 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 Exhibit 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 Contract Activities purchased under the Contract are for the State's exclusive use. Prices are exclusive of all taxes, and Contractor is solely responsible for payment of any applicable taxes.

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

    The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor must register with the State at http://www.michigan.gov/cpexpress to receive electronic fund transfer payments. If Contractor does not register, the State is not liable for failure to provide payment.

    Without prejudice to any other right or remedy it may have, the State reserves the right to set off at any time any amount then due and owing to it by Contractor against any amount payable by the State to Contractor under this Contract.

21. **Liquidated Damages.** Liquidated damages, if applicable, will be assessed as described in Exhibit 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 90 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.** 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 one business day of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to Contractor), an extract of the State Data in the format specified by the State.

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

e. Loss of Data. In the event of any act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise the security, confidentiality, or integrity of State Data or the physical, technical, administrative, or organizational safeguards put in place by Contractor that relate to the protection of the security, confidentiality, or integrity of State Data, Contractor must, as applicable: (a) notify the State as soon as practicable but no later than 24 hours of becoming aware of such occurrence; (b) cooperate with the State in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the State; (c) in the case of PII or PHI, at the State's sole election, (i) notify the affected individuals who comprise the PII or PHI as soon as practicable but no later than is required

to comply with applicable law, or, in the absence of any legally required notification period, within five calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for no less than 24 months following the date of notification to such individuals; (e) perform or take any other actions required to comply with applicable law as a result of the occurrence; (f) without limiting Contractor's obligations of indemnification as further described in this Contract, indemnify, defend, and hold harmless the State for any and all claims, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (g) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and, (h) provide to the State a detailed plan within 10 calendar days of the occurrence describing the measures Contractor will undertake to prevent a future occurrence. Notification to affected individuals, as described above, must comply with applicable law, be written in plain language, and contain, at a minimum: name and contact information of Contractor's representative; a description of the nature of the loss; a list of the types of data involved; the known or approximate date of the loss; how such loss may affect the affected individual; what steps Contractor has taken to protect the affected individual; what steps the affected individual can take to protect himself or herself; contact information for major credit card reporting agencies; and, information regarding the credit and identity monitoring services to be provided by Contractor. This Section survives the termination of this Contract.

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 five calendar days from the date of termination, return to the other party any and all Confidential Information received from the other party, or created or received by a party on behalf of the other party, which are in such party's possession, custody, or control; provided, however, that Contractor must return State Data to the State following the timeframe and procedure described further in this Contract. Should Contractor or the State determine that the return of any non-State Data Confidential Information is not feasible, such party must destroy the non-State Data Confidential Information and must certify the same in writing within five calendar days from the date of termination to the other party.

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 seven 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 fairly and accurately represents Contractor's business, properties, finances, and operations as of the dates covered by the information, and Contractor will inform the State of any material adverse changes; and (h) all information furnished and representations made in connection with the award of this Contract is true, accurate, and complete, and contains no false statements or omits any fact that would make the information misleading. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 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. **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.

42. **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 complied under MCL 423.322.

43. **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.

44. **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.

45. **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.

46. **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.

47. **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.

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

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

50. **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.

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

52. **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.

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

STATE OF MICHIGAN

Contract No. 071B5500060

Review and Certification of Inpatient (PACER) Admissions, Selected Durable Medical Equipment and Medical Supplies, Ventilator Dependent Care Unit Admissions and Continued Stays and Nursing Facility Level of Care– Michigan Department of Community Health

EXHIBIT A
STATEMENT OF WORK
CONTRACT ACTIVITIES

Project Request
This is a Contract for the Michigan Department of Community Health (MDCH) Review and Certification Program of Statewide Inpatient Admissions, Selected Durable Medical Equipment and Medical Supplies (DME/MS), Ventilator Dependent Care Unit (VDCU) Admissions and Continued Stays and Nursing Facility Level of Care.

Additional Services
The State may require additional services for other MDCH programs in the future. As such needs arise, the State may request a quote/proposal from the Contractor and, if the quote/proposal is acceptable, the State will incorporate the statement of work into the Contract through the formal Contract Change Notice process. This provision does not preclude the State from issuing a formal bid and awarding a separate contract(s) for the additional services.

Background
The MDCH is the single State agency responsible for health policy, the purchase of health care services and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this Contract is:

a. To have a qualified Contractor conduct telephonic review and electronic authorization of Inpatient Prior Authorization Certification Evaluation Review (PACER) services, selected DME/MS and VDCU Admissions and continued stays for the MDCH Fee For Service (FFS) Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries.
b. Validation to determine compliance with Medicaid Policy and Guidelines as outlined in the Provider manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.
c. To provide for the private administration of a State-wide Long Term Care (LTC) Admission Review and Nursing Facility Level of Care Criteria Determination certification required by Michigan's Medicaid Long Term Care Programs (Medicaid covered nursing facilities, MI Choice Waiver and the Program of All Inclusive Care for the Elderly [PACE]) that must utilize nursing facility level of care criteria. The Contractor must also conduct Long Term Care Nursing Facility Level of Care Exception Process reviews as exceptions to current Medicaid nursing facility eligibility as outlined in Medicaid Policy and the Medicaid Provider Manual. The Contractor must provide analytical reports regarding long term care utilization.

A review is considered a random sample of beneficiary records maintained by a provider to ensure services were medically necessary.

A random sample of beneficiary records/data for Inpatient PACER, selected DME/MS and VDCU Admissions and continued stays are reviewed by the MDCH Program Manager monthly to ensure services were medically necessary and authorization was granted appropriately.

The LTC Retrospective Reviews must be completed as per the requirements of Social Security Act §1919, [42 U.S.C. 1396r](a). MDCH has a policy specialist that determines the statistically valid random sample audits. LTC Retrospective Reviews are a post-payment review of a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider.

Attachment A lists MDCH definitions that are seen within the body of this Contract and when performing the Contract's requirements.

1.1 Requirements
A. Inpatient PACER/Long Term Care Immediate and Exception Review

1. The Contractor must perform a telephonic review/electronic authorization in compliance with Medicaid Program Policy and Procedure. This inpatient authorization will be conducted on Medicaid FFS (Title XIX), CSHCS dual eligible (Title V/XIX) beneficiaries.

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Contractor has a team of experienced registered nurses (RNs) who have been performing this telephonic review/electronic authorization. Practitioners or hospital providers call Contractor's toll-free Medicaid number and request prior authorization of elective admissions, 15-day readmissions into the same or different hospital, transfers from one acute inpatient setting to another, and admissions and continued stays (at days 30 and 60) for rehabilitation hospitalizations. Contractor's team of RNs utilizes McKesson's InterQual® criteria and Michigan Medicaid policy to screen for medical necessity of these services/settings.

Contractor's RNs also conduct telephonic/electronic authorization for MDCH selected Durable Medical Equipment (DME), Medical Supplies (MS), and Ventilator Dependent Care Unit (VDCU) utilizing Michigan Medicaid policy. Contractor's staff evaluates whether the DME or MS is a covered service under Michigan Medicaid and if the information provided supports medical necessity for the service. For ventilator dependent Medicaid beneficiaries, the RN determines if an admission or continued stay in a VDCU is medically appropriate.

Because clinical information is requested by providers, RNs perform this review. RN reviewers determine if the clinical information is sufficient to justify the service/setting being requested or if further clinical information must be obtained. If the RN can approve the case because it meets InterQual® criteria and/or Medicaid policy, entry into Michigan's Community Health Automated Medicaid Processing System (CHAMPS) is completed and the provider is given an authorization number which is generated in CHAMPS.

In the event the RN is unable to approve the service/setting requested, the case is immediately forwarded to a Contractor physician reviewer to assess the appropriateness of the service/setting requested. The physician reviewer contacts the practitioner to get additional information about the Medicaid beneficiary and why the practitioner has requested the service/setting. Talking peer-to-peer with the requesting physician helps the physician reviewer understand the practitioner's thought process. Following the discussion, the physician reviewer considers all available information and considers Michigan Medicaid policy as well as the standards of care, (s)he makes a determination regarding whether to approve or deny certification for the service/setting. The reason for the approval or denial is entered into CHAMPS by the Contractor physician reviewer. A RN immediately notifies the provider/practitioner of the decision. If the case is approved, the RN assigns an authorization number; however, if Contractors physician reviewer denies the service/setting, the provider/practitioner is notified of their right to request reconsideration and the timeframe for such. This conversation is documented in CHAMPS. Some providers/practitioners/DME providers require written notification. Contractor sends that communication by facsimile or through the Unites States Postal System (USPS).

For certain services/settings Contractor has denied, MDCH requires Contractor to inform the Medicaid beneficiary of any adverse determination, reduction, or termination of services. For those required services/settings, Contractor's RN generates a letter and sends it to the Medicaid beneficiary the same day the adverse action was made. The letter contains the reason for the adverse action and how to file an appeal. In addition, the letter includes an Appeal Request form and an addressed stamped envelope.

a. For LTC, the review will be conducted on Medicaid FFS, and possibly Medicare/Medicaid beneficiaries.

. Contractor's technological approach and review criteria meet the LTC exception criteria developed by MDCH.

Michigan's nursing facility Level of Care Determination (LOCD) is a web-based tool that determines an applicant's medical/functional eligibility for Michigan's Medicaid-covered nursing facilities, Michigan's Home and Community Based Waiver for Elderly and Disabled (MI Choice Program), and the Program of All Inclusive Care for the Elderly (PACE). In instances when a Medicaid beneficiary doesn't qualify for admission or no longer qualifies to continue with nursing facility level of services, the provider has two

options: 1) they can contact Contractor for an exception review or 2) they can issue an Adverse Action Notice.

Contractor performs "immediate" reviews when a beneficiary has received an Adverse Action Notice from the nursing facility or community-based waiver program advising them that they do not meet admission or continued stay LOCD criteria. Slight differences in those two reviews follows:

Exception Review	Immediate review
Provider is unable to get Medicaid beneficiary to meet LOCD criteria; but thinks Medicaid beneficiary may qualify under exception criteria.	Provider is unable to get Medicaid beneficiary to meet LOCD criteria and does not believe Medicaid beneficiary will qualify under exception criteria. Provider Issues Adverse Action Notice to Medicaid beneficiary.
Provider Requests review	Medicaid beneficiary requests review
Review is telephonic	MPRO requests medical record from provider
If approved; entered into CHAMPS LOCD as approved; if denied RN sends adverse action notice to Medicaid beneficiary.	If approved; entered into CHAMPS LOCD as approved; if denied RN sends adverse action notice to Medicaid beneficiary.

Contractor will perform LTC exception reviews through a review of relevant clinical information based upon exception criteria determined by MDCH. The following is a summary of the current exception criteria according to MDCH Medicaid policy.

MDCH EXCEPTION CRITERIA

Frailty

The beneficiary has a significant level of frailty as demonstrated by at least one of the following categories:

- Applicant demonstrates late loss Activities of Daily Living (ADLs) (i.e., bed mobility, toileting, transferring, and eating);
- Applicant performs ADLs independently, but requires an unreasonable amount of time;
- Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity;
- Applicant has experienced at least two falls in the home in the past month;
- Applicant continues to have difficulties managing medications despite the receipt of medication set-up services;
- Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services; and
- Applicant meets criteria for Door 3 when ER visits for clearly unstable conditions are considered.

Behaviors

The beneficiary has at least a one-month history of any of the following behaviors and has exhibited two or more of these behaviors in the past seven days:

- Wandering;
- Verbal or physical abuse;
- Socially inappropriate behavior; or
- Resists care.

Treatments

The beneficiary has demonstrated a need for complex treatments or nursing care.

RETROSPECTIVE LONG TERM CARE REVIEW

Each month Contractor provides a random sample selection of Medicaid beneficiaries who qualified through the LOCD tool. The review focuses on validation of what the providers entered into the tool with the

documentation in the medical record/case file. Contractor initially performed the review of these cases and educated the providers regarding modifications or denials.
Any retrospective review in which Contractor found a beneficiary to be ineligible for nursing facility level of care could result in the State's recoupment of any money paid to the provider/program for the admission or continued stay in the nursing facility, MI Choice Waiver Program or PACE program. The provider can appeal these findings through the DCH Hearings and Appeals process. Contractor represents our determinations at all levels of appeals.
Annual reports support that Contractor's review findings are helping the State recover money on nursing facility LOC services that were paid by MDCH.

2. The Contractor must conduct the following reviews:
   a. Inpatient PACER, telephonic/electronic for Medicaid Fee For Service (Title XIX), CSHCS dual eligible (Title V/XIX) beneficiaries. MDCH anticipates approximately 12,675 calls annually.

   b. LTC Immediate Reviews of the medical record or case file, and LTC Exception Reviews-telephonic/electronic reviews for exceptions to Michigan Medicaid Nursing Facility Level of Care Determination for nursing facility Medicaid beneficiaries, MI Choice Waiver and the PACE participants. MDCH anticipates approximately 160 Long Term Care Exception and 100 Long Term Care Immediate requests annually.

   c. LTC Retrospective Reviews must be conducted on Medicaid Fee for Service (Title XIX) and Medicare/Medicaid beneficiaries (Title XVIII/XIX), of Nursing Facilities, MI Choice Waiver and PACE utilizing statistically valid random samples. The average number of Medicaid beneficiaries to be reviewed for the combined Medicaid reimbursed Nursing Facilities MI Choice Waiver and PACE for each quarter is 450.

Contractor's technological approach and review criteria meet the LTC exception criteria developed by MDCH.
Contractor has a toll-free number established for the providers to call for prior authorization and LTC exception review. The provider gives Medicaid beneficiaries the same number when they issue an Adverse Action Notice, so the beneficiary can request Contractor to conduct a LTC immediate review.

Contractor has established efficiencies and a dedicated Access database where each review is tracked and the decisions recorded. With MDCH's specifications, Contractor designed database to assure key elements were captured and, whereby, accurate monthly reports can be generated and reported back to MDCH. The key elements captured include:

1. The time period under review;
2. An assessment whether a Preadmission Screening and Resident Review (PASRR). PASRR is a federal requirement to help ensure individuals are not inappropriately placed in nursing homes for LTC;
3. An assessment regarding whether Freedom of Choice was made available to the Medicaid beneficiary;
4. The LOCD criteria the provider used to approve the beneficiary;
5. The LOCD Contractor approved the case under;
6. Contractor denial and the time period denied;
7. Date completed by Contractor;
8. Date billed by Contractor; and
9. Appeal information.

3. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks, or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:
   a. Responsibility for the authorization must be implemented no later than the first day of this Contract.
   b. This process must be continued through the Contract termination date.

   c. The telephone and computer systems must be available from 8 a.m. - 5 p.m. EST Monday through Friday except for State approved/sanctioned holidays.

d. Providers must be notified 30 days prior to an approved holiday.

Thirty days prior to a MDCH-approved holiday, Contractor puts an "entrance" message on the telephone, so when a provider/practitioner calls they hear the message about closure. In addition, each year Contractor posts closures on Contractor's website. Lastly, annually, once Contractor's Board approves holidays, they are sent to MDCH for formal approval.

e. The Contractor must be Health Insurance Portability and Accountability Act (HIPAA) compliant.

Contractor's review team follows Contractor's HIPAA-compliant confidentiality and disclosure policy and adheres to the terms of MDCH's HIPAA requirements. Audit documentation, claims information, medical records, and findings are maintained in strict confidence and not disclosed to third parties without MDCH's prior written approval

f. Telephonic and Computer Electronic systems must be in place on the Contract start date.

g. The Contractor must assign staff to represent MDCH in the Appeals Process.

h. The Contractor must assign Inpatient PACER authorization numbers and have/make available the documentation provided at the time of Inpatient PACER number requests (i.e. Registered Nurse (RN)) reviewer and/or Physician reviewer documentation and summary).

Contractor's RNs perform all reviews in Michigan's Medicaid web-based system, CHAMPS. Authorization numbers (aka tracking numbers) are given to providers when the RN can approve the service/setting. The RN documents case specifics in CHAMPS, including criteria/Michigan Medicaid policy used to approve the case. If the RN is unable to approve the case, it is forwarded to Contractor's physician reviewer who considers all available information and discusses the case with the practitioner who ordered the service/setting. The Contractor's physician reviewer documents his/her decision in CHAMPS. The RN follows up with appropriate notification to the provider/practitioner and Medicaid beneficiary, if necessary.

i. The Contractor must have a system or process in place that allows the validation of LTC Immediate Review and LTC Telephonic Exception Review.

If Contractor receives a request for a LTC exception or LTC immediate review, the RN uses CHAMPS to launch the LOC Determination application.

j. The Contractor must utilize the MDCH Community Health Automated Medicaid Processing System Program (CHAMPS).

The RNs use the PA (prior authorization) section of CHAMPS to screen for existing cases and to start a new review if an existing case is not there. During the review, the RN asks the caller if the Medicaid beneficiary has FFS Medicaid, Healthy Michigan, or Children's Special Health Care Services (CSHCS). While performing the review, the RN also checks in CHAMPS to validate Medicaid eligibility.
After completing all the required information, our RNs must complete the actual review case summary information in Summary Requests.

If the RN or Contractor physician reviewer clicks on Add Comments, they can add any information relevant to the case.

k. Potential Quality of Care issues will be referred to the MDCH Program Manager for MDCH Office of Medical Affairs (OMA) review and reporting to the Bureau of Health Professions – Health Regulatory Division for investigation if there is agreement from the OMA physician after review.

RNs refer any potential quality of care concerns to a Contractor physician reviewer. If the physician reviewer determines a quality of care concern exists, Contractor refers it to the MDCH Program Manager for MDCH OMA review.

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4. A copy of the information received from the provider at the time the Inpatient PACER number authorization was requested must be retained by the Contractor. The information received from the provider for Inpatient PACER authorization both approvals and denials, including the Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy for seven years.

Contractor stores the electronic documentation in a secure online database for easy retrieval. Contractor stores hard copy denials, reconsiderations, and appeals in our secured medical records room for one year and then Contractor sends the documentation to a secure off-site storage facility for the remaining six years.

5. A copy of the information received from the provider at the time the LTC immediate review was requested must be validated by the Contractor. The information received from the provider for the LTC Immediate review, including Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy for seven years.

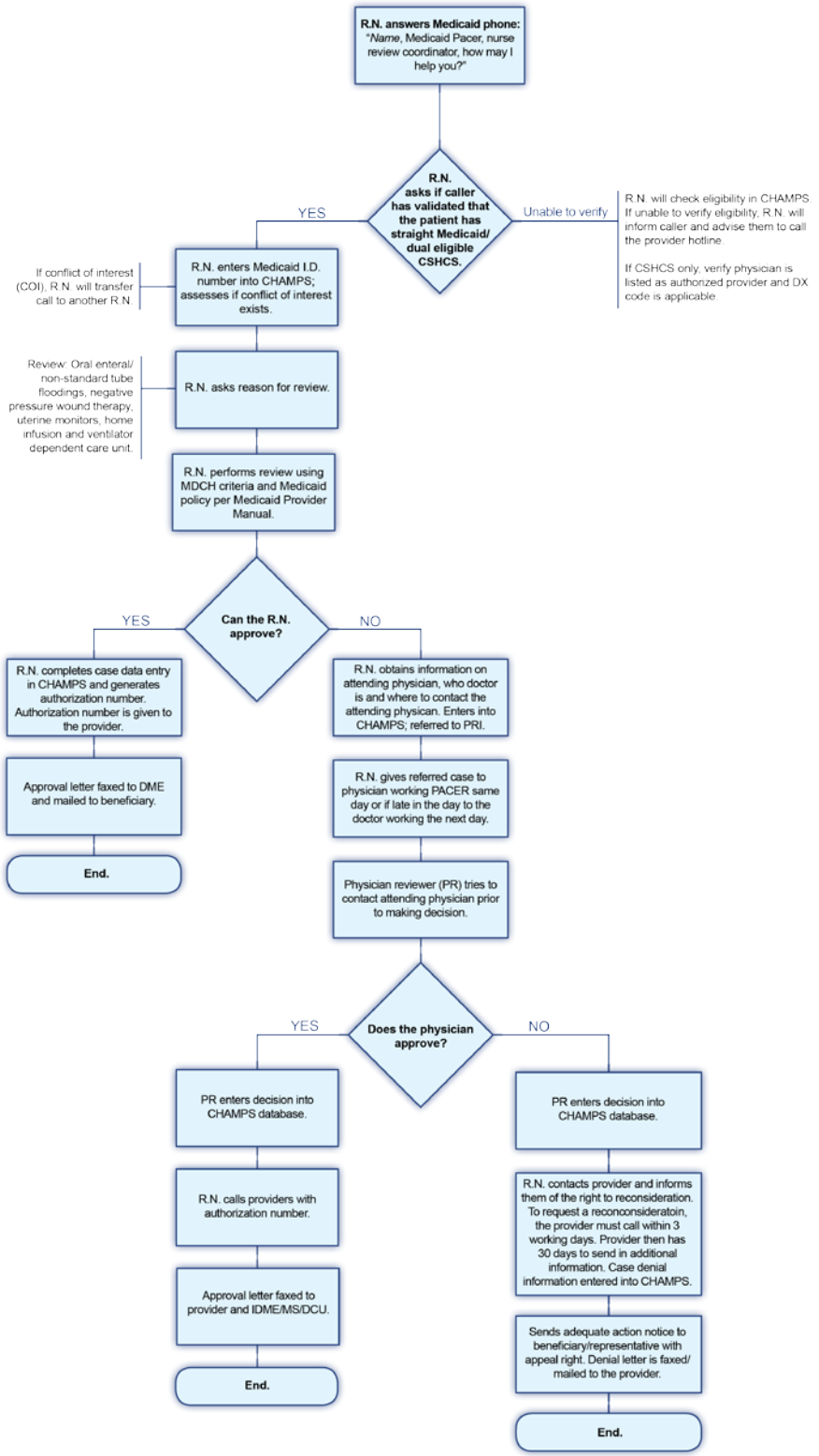
   Contractor electronically stores all approval documentation for seven years and stores denials both electronically and via hard copy for the same seven-year period.
6. A copy of the Review Coordinator's summary for the LTC Telephonic Exception review must be stored electronically for seven years.

   Contractor enters all data relevant to the LTC Telephonic Exception review into the LOC Determination section of the State's web application portal. The information contained in the database is outside Contractor's jurisdiction.

B. Telephonic Review/Electronic Prior Authorization for MDCH Selected DME/MS and VDCU Admissions and Continued Stays

1. The Contractor must perform a telephonic review/electronic authorization in compliance with MDCH/Medicaid/CSHCS policies and procedures for selected DME/MS and VDCU Admissions and continued stays for beneficiaries covered under the Medicaid FFS [Title XIX] and CSHCS Program [Title V and Title V/XIX]. MDCH anticipates approximately 6,825 calls annually.

   The following chart shows the process flow for a telephonic review request:



As shown in the flow chart above, the RN must first determine what the call is for and whether the beneficiary is Medicaid or CSHCS eligible. The review must come from a physician or their designee (office or hospital staff) who calls it into Contractor or submits the information via CHAMPS.
Contractor uses a form to determine if the Medicaid/CSHSC beneficiary meets criteria for enteral supplements.

This form is available on Contractor's website if the provider chooses to complete it and upload it into CHAMPS or fax it to Contractor.

If the RN can approve the request, a calculation is made regarding how much formula over an approved period time the beneficiary will need. The RN converts the amount of calories into units and enters the information into CHAMPS, with the specific code to reflect that it is enteral (EN). The RN notifies the provider by phone of the authorization and then sends an approval letter via facsimile to the provider and DME supplier. As with the other review types, if the RN cannot approve the request for the service, he/she immediately forwards the case to a Contractor physician reviewer.

The physician reviewer contacts the practitioner to get additional information about the Medicaid beneficiary and why the practitioner has requested the service/setting. Talking peer-to-peer with the physician helps the Contractor physician reviewer understand the practitioner's thought process and details regarding their request. Following the discussion, the Contractor physician reviewer considers all available information, which includes Michigan Medicaid policy and the standards of care, and makes a determination regarding whether to approve or deny certification for the service/setting. The physician reviewer then enters the reason for approval or denial into CHAMPS, and a registered nurse notifies the provider/practitioner of the decision. If the case is approved, the RN assigns an authorization number; however, if Contractor physician reviewer denies the service/setting, the provider/practitioner is notified of their right to request reconsideration and the timeframes required to request a reconsideration. This conversation is documented in CHAMPS. Some providers/practitioners/DME providers require written notification. Contractor sends that communication by fax or through the USPS.

2. The Contractor must set up a process to receive and respond to requests for PA for MDCH selected DME/MS by telephone, fax, or electronically through the MDCH CHAMPS system. These reviews include the MDCH selected DME/MS codes and VDCU Admissions and continued stays.

   The MDCH selected DME/MS include:
   a. Negative Pressure Wound Therapy
   b. Enteral Nutrition – Oral and Tube Feeding over 3000 calories
   c. Parenteral Nutrition – TPN and related supplies
   d. Infusion therapy
   e. Home Uterine Activity Monitors

   Contractor has a dedicated toll-free telephone number that providers can call in real time to request prior authorization for MDCH-selected DME/MS services that include:
   a. Negative pressure wound therapy
   b. Enteral nutrition – oral and tube feeding over 3,000 calories
   c. Parenteral Nutrition – TPN and related supplies
   d. Infusion therapy
   e. Home uterine activity monitors

   Contractor has a dedicated facsimile for PACER/DME/MS/VDCU review requests and Contractor's RNs all have MDCH-approved access to CHAMPS to electronically receive prior authorization review requests. If Contractor receives a request electronically or via fax, the RN and physician review is the same as if Contractor received the request telephonically. The only difference, at times, is when providers submit information via facsimile or electronically through CHAMPS and all the information has not been provided. The RN then contacts the provider by phone and requests the missing information. If a phone number was not provided, the RN will fax or electronically send a request through CHAMPS for additional and/or clarifying information.

   If there is a denial of any services or reduction in services, Contractor sends the Medicaid beneficiary or their representative a letter advising them of the denial/reduction in services. The letter contains their right to appeal the denial/reduction in services and includes an addressed stamped envelope and the DCH-0092 Request for Hearings form.

3. The Contractor must be able to receive telephonic, electronic, or faxed requests from the clinical practitioners and/or the VDCU and then provide the medical supplier with the PA number, if approved. If denied, the Contractor must send the beneficiary a notice of due process rights or departmental review (Attachment B).

   Contractor has a toll-free telephone number that providers can call in real time to request prior authorization for requests for VDCU prior authorization. Contractor also has a dedicated facsimile for

PACER/DME/MS/VDCU review requests and Contractor's RNs all have MDCH-approved access to CHAMPS to electronically receive prior authorization review requests. If Contractor receives a request electronically or via fax, the RN and physician review is the same as if we received the request telephonically. The only difference, at times, is when providers submit information via facsimile or electronically through CHAMPS and all the information has not provided. The RN then contacts the provider by phone and requests the missing information. If a phone number was not been provided, the RN will fax or electronically send a request through CHAMPS for additional and/or clarifying information.

As the process flow chart describes, Contractor notifies the provider of the review determination by phone and, if approved, assign it an authorization number. This is followed by a letter to the provider. If there is a denial of DME/MS/VDCU services, the provider is informed of their right to request reconsideration and how to request one. The Medicaid beneficiary or their representative is sent a letter advising them of the denial in services. The letter contains their right to appeal the denial/reduction in services and includes an addressed stamped envelope and the Request for Hearings form. All of this information is documented in CHAMPS. The RN utilizes a MDCH-specific code to reflect the review type in CHAMPS.
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4. The Contractor must be able to receive telephonic, electronic, or faxed requests from the VDCU representative and provide the VDCU representative with the PA number, if approved. If denied, the Contractor must send the beneficiary a notice of due process rights or departmental review (Attachment B).

   Also see Section 1.1.B.3 for process. The RN utilizes the MDCH code "VT" to reflect it is a VDCU case in CHAMPS

5. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks, or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:

   a. The telephone and computer system must be available from 8:00 a.m. – 5 p.m. EST Monday through Friday except for State approved/sanctioned holidays.

   b. Providers must be notified 30 days prior to an approved holiday. A notice will be placed on Contractor's phone message of closures [i.e. State approved holidays or for training].

      Contractor puts an "entrance" message on the telephone, so when a provider/practitioner calls they hear the message about closure. In addition, each year Contractor posts closures on website. Lastly, once Contractor's Board approves Contractor's holidays, Contractor sends them to MDCH for formal approval.

   c. The Contractor must be HIPAA compliant.

      Audit documentation, claims information, medical records, and findings are maintained in strict confidence and not disclosed to third parties without the prior written approval of MDCH.

   d. Telephonic and Computer Electronic systems must be in place on the Contract start date and continue through the Contract termination date.

      Contractor is committed to making sure all systems are maintained adequately.

   e. The Contractor must assign staff to represent MDCH in the Appeals Process.

   f. The Contractor must establish and make available for practitioner use an information sheet that can be completed and faxed or submitted electronically from the practitioner.

      Contractor's website provides practitioners access to forms they can use to fax or electronically submit a request for review. The available forms are: request for retrospective review, request for enteral or parenteral, and request for negative pressure wound therapy. Contractor will add an infusion and uterine monitoring request form upon contract award.

g. The Contractor must utilize MDCH Office of Medical Affairs physicians for consultation as to clinical appropriateness of care if required by MDCH. The Contractor must have available the appropriate subspecialists for reviews for CHSCS children as required in MDCH published policy.

Contractor's physician review network is an integral component of Contractor's Utilization Review Program. To provide a full range of clinical review services, Contractor's network consists of more than 150 actively practicing, board-certified, credentialed, and experienced physician reviewers who represent the entire spectrum of medical specialties and subspecialties. Each clinical reviewer must complete a rigorous screening process and, to ensure consistency and reliability, each reviewer must be re-credentialed every two years. Contractor utilized Michigan-based physicians familiar with local standards of care for peer-to-peer review activities

h. The Contractor must utilize the MDCH CHAMPS Program.

The RNs use the PA (prior authorization) section of CHAMPS to screen for existing cases and to start a new review if an existing case is not there. During the review, the RN asks the caller if the Medicaid beneficiary has FFS Medicaid, Healthy Michigan, or Children's Special Health Care Services (CSHCS). While performing the review, the RN also checks CHAMPS to validate Medicaid eligibility.

i. Potential Quality of Care issues must be referred to the MDCH Program Manager for OMA review and reporting to the Bureau of Health Professions – Health Regulatory Division for investigation if there is agreement from the OMA physician after review.

6. Inpatient PACER Validation:

A random sample of Inpatient PACER authorization validations will be conducted as part of the process on all Medicaid Fee For Service (Title XIX), CSHCS dual eligible (Title V/XIX) beneficiaries who had a request for Inpatient PACER through the Contractor. The RN performing this validation will be the MDCH Program Manager. The number of cases to be selected on a monthly basis is determined by the MDCH.

If the Contractor inappropriately authorizes a service that does not meet MDCH standards of coverage (Attachment N), approved criteria for exceptions, or is not determined to be a medically appropriate exception, the Contractor will be responsible for reimbursement to the State for coverage of the service.

Contractor understands the MDCH Program Manager will conduct validation of cases that Contractor reviews. In addition, we understand that PACER/DME/MS/VDCU and LTC must be authorized appropriately according to criteria and Medicaid policy and how an inappropriate authorization would be costly to MDCH. Contractor has an internal process to monitor review process. The following describes Contractor's process:

Quarterly, the RN PACER Manager randomly selects at least 10 cases from each nurse for inter-rater reliability. The PACER, DME/MS/VDCU review, LTC exception or LTC immediate review is blinded and given to all Contractor's nurses to review. The review consists of assuring:

- Data entry is accurate and complete;
- Review timeframes are met;
- Criteria used to approve the case are present and validated;
- Medicaid policy was followed; and
- Referrals to Contractor physician reviewers are appropriate.

If issues arise, Contractor addresses them individually Each month our PACER review team meets to discuss changes in Medicaid policy, current evidenced-based standards, and performance indicators.

Contractor also performs inter-rater reliability for our physician reviewers; however, Contractor's Medical Director is responsible for overseeing this process.

Directors must be licensed health care professionals and hold an unrestricted license with post-graduate experience in direct patient care.

7. Selected DME/MS and VDCU Admissions and Continued Stay Validations:
   A random sample of selected DME/MS authorizations and VDCU Admission/continued stay authorizations will be conducted as part of the review process on all FFS Medicaid and CSHCS dual eligible beneficiaries who had a request for a selected DME/MS service or an admission or continued stay in a VDCU through the Contractor. The RN performing this validation will be the MDCH Program Manager. The number of cases to be selected on a monthly basis is determined by the MDCH.

   If the Contractor inappropriately authorizes a service that does not meet MDCH standards of coverage, approved criteria for exceptions, or is not determined to be a medically appropriate exception, the Contractor will be responsible for reimbursement to the State for coverage of the service.

8. LTC Retrospective Review:
   LTC Retrospective reviews must be performed based on current Michigan Medicaid Nursing Facility Level of Care Determination criteria or, for beneficiaries who qualified via the Nursing Facility Level of Care Exception criteria. Retrospective Reviews will be conducted for Medicaid beneficiaries of nursing facilities and MI Choice Waiver and PACE. Retrospective reviews are conducted strictly to determine appropriate utilization, however, serious quality issues will be referred by the Contractor to the Health Policy, Regulation, and Professions Administration.

   The Contractor will be paid per review completed for all of the above categories.

C. Inpatient PACER/MDCH Selected DME/Medical Supply and Ventilator Dependent Care Unit Admissions/Continued Stays Telephonic Review

1. The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared in violation of HIPAA guidelines.

   The PACER review process is conducted in accordance with the guidelines and timeframes MDCH established.

2. The Contractor must provide a telephonic and electronic PA process for the review of Inpatient PACER, selected DME/MS and VDCU Admissions and continued stay requests. The Contractor must also provide access and utilize the MDCH CHAMPS system that must include, at a minimum, all of the following:

   a. Clinically experienced RN to receive the authorization requests, elicit all relevant information, and reach an initial decision based on admission criteria approved by MDCH;

   b. Use of appropriately qualified physicians and appropriate pediatric subspecialists or assigned MDCH OMA physician to assist the RN in their decision as appropriate, to query requesters in all questioned requests, and render all denial determinations;

      All of Contractor's physician reviewers are board certified and in active practice. They are all Michigan-licensed physicians. Physician reviewers encompass the spectrum of reviewer specialty types including, but not limited to, pediatric subspecialists. Physician reviewers are the only ones who make a denial determination. The physician reviewer uses clinical knowledge and judgment, knowledge of state and federal regulations, and additional clinical information obtained from discussions with the attending physician to determine if the proposed care is within the definition of current standards of care and is appropriate for Medicaid coverage. The physician reviewer determination is entered into CHAMPS and the rationale is documented in comments.

   c. Render and communicate by telephone, electronic computer system, or fax all authorization decisions on the same day requested;

   d. Generate and communicate to the requesting provider a unique, identifying Inpatient PACER number for each authorized case;

      If a RN or Contractor physician reviewer approves a case, then the provider is given a CHAMPS generated authorization number.

e. Data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for PA;

The information stated in the above requirement (e.) is captured in CHAMPS. Our RN assures the Medicaid beneficiary identification number is entered into the system and then verifies that eligibility exists. This information is documented in the Comment section of the applicable screen. The RN and Contractor physician reviewers attest to an absence of a conflict of interest. If one were to exist, the case would be transferred to another reviewer to complete. In addition, other relevant demographic information is captured in the system, such as dates of service, reason for review, provider on record, and codes (if applicable). Contractor is able to retrieve the information from CHAMPS if the provider submits it through the file exchange or we enter the information into CHAMPS if a provider faxes a request to us.

f. The Contractor must maintain a toll-free Inpatient PACER/PA telephone number. The Contractor must answer all incoming phone calls promptly with average time to answer of less than 90 seconds; and

g. The Contractor must input all authorization decisions into the MDCH CHAMPS system.

3. The Contractor must review and authorize all elective inpatient hospital admissions, all re-admissions within 15 days, all transfers between hospitals and between units within a single hospital having different Medicaid ID/National Provider Identifier/Taxonomy Code numbers or provider types, and all admissions and continued stays for inpatient rehabilitative facilities for FFS Medicaid, CSHCS dual eligible and CSHCS beneficiaries.

4. The basis of the decisions must include the medical need and appropriateness of the following:

a. The condition to be treated on an inpatient basis;
b. To have treatment continued for rehabilitative facilities;
c. To be treated at another hospital if already hospitalized;
d. To be re-hospitalized.

For each a review, the RN assesses the appropriateness of the setting, utilizing InterQual® criteria, Michigan Medicaid policy, and their clinical expertise. RNs attend web-based trainings on changes to InterQual® criteria, which typically occur annually. RNs address Michigan Medicaid policy changes and review MSA Bulletins at their monthly meetings.

Elective Admissions –RNs evaluate whether the proposed service is on the Medicare *Inpatient Only List* This is relevant because Medicaid follows Medicare billing rules. In addition, the RN evaluates the criteria for condition specific settings, severity of illness, and intensity of service.

Rehabilitation Admissions and 30/60-Day Continued Stay in a Rehabilitation Facility –RNs use InterQual® rehabilitation criteria to determine the medical necessity of an acute inpatient rehabilitation hospital stay. They evaluate for continued stay, evaluate progress and goals, and assure it continues to meet criteria.

Transfers from One Acute Care Hospital to Another – These situations are reviewed for a higher LOC. RNs inquire about why the beneficiary is being transferred and if the necessary/needed services are available at the current hospital. Transfers for convenience or social reasons are referred. Transfers that are not eligible for a higher LOC are referred, with one MDCH exception. Neonates can be transferred back to the original hospital for teaching and bonding.

15-Day Readmissions –RNs review 15-day readmissions to evaluate whether the readmission was related to the first admission. They assess if the readmission is due to the beneficiary being prematurely discharged from the first admission, where services that could have been provided during the first admission were not which may have contributed to the readmission. This is a very complex review. In addition, RNs screen, using InterQual® criteria, to assure the readmission is medically necessary in an acute inpatient setting. They use the MDCH Medicaid “Guidelines for Hospital Readmissions within 15 Days.”

Referrals to Contractor Physician Reviewers – These referrals occur when a RN cannot approve (authorize) an elective admission, rehabilitation admission or continued stay, transfer, or 15-day readmission. Though not discussed in this section, the same applies to DME/MS/VDCU authorization.

Nurses can only certify (approve) a service or setting as medically necessary; they cannot deny. When a RN cannot authorize the service or setting, the case is referred to a Contractor physician reviewer.

Physician Reviewers – Contractor physician reviewers are an integral component of our utilization review program. Contractor's professional review network is comprised of more than 150 licensed, board-certified, and credentialed physicians. Contractor has experienced physician reviewers representing the entire spectrum of medical specialties and subspecialties.

In addition, physician reviewers are knowledgeable in local standards of care for peer-to-peer review activities as well as Medicare and Medicaid principles. They are also experienced in nursing care and utilization review procedures. Specifically, physician reviewers are experts in:

- Utilization review for various services and settings.
- LTC and Michigan's Medicaid criteria; and
- Inpatient hospital admission criteria approved by MDCH and nursing facility LOC exception criteria.

The physician reviewers who work in Contractor's PACER group collectively have more than 10 years' experience performing review in this area. At the reconsideration level, Contractor sends cases to the same specialty physician as the physician who provided the care.

Contractor keeps physician reviewers abreast of current trends and changes in Medicare and Medicaid principles through quarterly education sessions, newsletters, and hands-on orientation and collaboration. They also have current knowledge and clinical experience, have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity and have no conflicts-of-interest with any case under review. These physicians maintain active medical practices while participating in our medical review processes and/or committee activities. More than 25 of Contractor's physician reviewers are also board-certified from the American Board of Quality Assurance and Utilization Review Physicians.

Denials for inpatient admissions and any changes to an existing request must be entered into the MDCH CHAMPS system. The Contractor must send an adequate action notice to FFS Medicaid and Medicaid/CSHCS dually enrolled and CSHCS only beneficiaries explaining/describing why the service was denied. The letters are State determined and in the CHAMPS system for Contractor use. The beneficiary will be notified of a denial of services for an elective admission. An appeals form (DCH-0092 Hearing Request – Attachment B) provided by the State must accompany the adequate action notice to the beneficiary. The adequate action notice and appeal form must be sent to the beneficiary the day of the action. Copies of all adequate action notices must be sent to the MDCH Program Manager on a monthly basis. Transfers and readmissions within 15 days do not need a notice to the beneficiary as no services were suspended, terminated, or reduced.

Providers are notified verbally at the time of the telephonic/electronic request and given provider appeal rights verbally at the same time (General Information for Providers Chapter, Section 9.1 of the Medicaid Provider Manual).

5. Authorizations for the MDCH selected DME/MS and VDCU for FFS Medicaid, CSHCS dual eligible and CSHCS only beneficiaries must be based on the MDCH published standards of coverage and/or exceptions based on medical necessity within established standards of practice.

Denials for the MDCH DME/ MS and VDCU authorization and any changes to the request must be entered into the MDCH CHAMPS system. The Contractor must send a Notification of Denial/Request for Administrative Hearing letter to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries explaining/describing why the service was denied. The letters are State determined and in the CHAMPS system for Contractor use. The beneficiary must be notified of a denial of within 10 days of the decision date. An appeals form (DCH-0092 Hearing Request – Attachment B) provided by the State must accompany this notice to the beneficiary. Copies of all Notification of Denial/Request for Administrative Hearing letters must be sent to the MDCH Program Manager on a monthly basis.

Contractor following this process with the exception that Contractor mails letters to the beneficiary notifying them of the denial on the same day the decision was made.

A Notification of Denial/Request for Department Review must be sent to CSHCS only beneficiaries within 10 days of the decision date.

Contractor follows this process with the exception that Contractor mails letters to the beneficiary notifying them of the denial on the same day the decision was made.

6. It is essential that the Contractor have the capability to access and utilize the MDCH CHAMPS system for all Inpatient PACER and MDCH selected DME/MS and VDCU requests.

   The MDCH CHAMPS system reads the Inpatient PACER, selected DME/MS and VDCU authorization numbers, compares information, and suspends or denies payment of inappropriate claims for various reasons by edits.

   Each type of review inpatient PACER, selected DME/MS, VDCU has their own requirements regarding data entry. Failure to input the correct data could result in delay in payment of provider claims. Contractor assists CNSI (MDCH contractor) and MDCH in testing revisions in CHAMPS that relate to the PACER/DME/MS/VDCU review.

7. The Contractor must develop a process for Inpatient PACER, selected DME/MS and VDCU reviews which must include all of the following:

   a. The review is initiated by the attending physician or other designated staff in the physician office by telephone or electronically requesting PA. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all PA requests including all denial correspondence.

      Contractor has processes in place to assure the review is initiated by the attending physician or designated staff in the physician office by phone or electronically. RNs follow the Medicaid provider manual, which describes who can provide review information. This has recently been revised in the MDCH provider manual to include nurse practitioners and physician assistants. Contractor has strict guidelines to assure the confidentiality and security of the beneficiaries and providers are respected. Any information we send electronically is sent securely. When Contractor sends information via fax, Contractor verifies the phone number with the intended recipient and requests confirmation of receipt. When Contractor uploads a decision into CHAMPS, Contractor makes sure Contractor notifies the intended recipient by email or phone to let them know to expect it. In turn, Contractor asks for confirmation of receipt.

   b. In a hospital to hospital transfer or readmission within 15 days, should the transferring physician not obtain an authorization as required, the receiving physician or second hospital may request this before the beneficiary is discharged.

   c. All Inpatient PACER requests must minimally include: beneficiary ID number, sex, birth date, county of residence, procedure code, hospital name, transfer code (transfer, readmission, urgent/emergent/elective), discharge date of first admission, justification code (reason for admission), and patient's name (required for physician advisor referrals).

      Some of the information is populated into CHAMPS once the Medicaid beneficiary ID is verified; however, the RN must validate eligibility in CHAMPS. The RN enters the reason for the prior authorization request, elective admission, readmission, transfer, rehab 30/60 day, or DME/MS/VDCU (has specialty codes). The RN also indicates in CHAMPS how the information was received. There is a dropdown box the RN selects (phone/mail/fax/DDE-278 Provider/DDE/Batch278). If a case is referred to a Contractor physician reviewer, the RN includes the name, phone number, and specialty of the ordering physician as well as the name and phone number of the person who requested the authorization in the Comments section. Additional information includes whether the person who requested the authorization number has a confidential voicemail, so Contractor can leave the decision on the phone if the caller is not available.

8. If the Severity of Illness/Intensity of Service (SI/IS) admission criteria approved by MDCH and/or Policy are met, the Contractor's nurse approves the admission and an Inpatient PACER authorization number is issued to the physician. The number is valid for 30 days and must be entered on hospital claims for payment for the hospital stay.

When an authorization number is given because admission criteria is met, RNs advise the requesting provider that they must notify us if the date of service changes because this could impact payment. In addition, Contractor only removes the "from" date in CHAMPS 30 days for these types of reviews.

9. If the McKesson InterQual® criteria are not met or if there are any questions requiring medical judgment, the case must be referred to a Contractor's physician consultant or MDCH OMA designated physician by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety-eight percent of referred cases must be resolved; either approved or denied for Medicaid coverage by the Contractor, the same day the request was received. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor must report all adverse determinations to the MDCH after the reconsideration process is completed.

10. Requests for reviews for selected DME/MS are initiated by the referring physician or other designated staff in the physician's office and can be done telephonically, electronically, or by fax. Review requests for VDCU Admissions and continued stays are initiated by the VDCU and are done telephonically. The Contractor RN reviewer validates eligibility and enters pertinent information into the CHAMPS system. The review and decision is performed based on MDCH published standards of coverage and/or exceptions based on medical necessity within established standards of practice care (FFS Medicaid policy, FFS Medicaid Bulletins, OMA physician input).

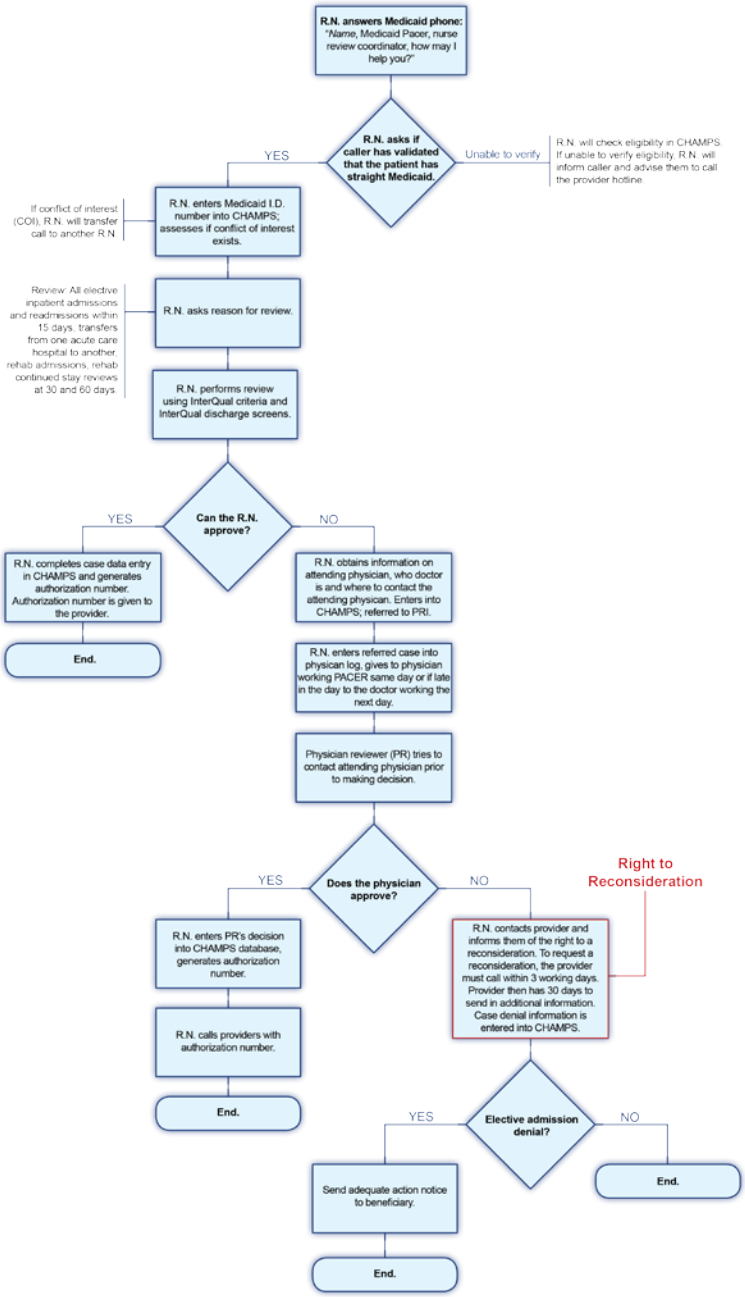
    If the information provided meets the above criteria, the Contractor RN reviewer will generate an authorization number and give it to the physician or their designee. If the information does not meet medical necessity and/or Standards of Care criteria in policy, the Contractor RN reviewer elevates the request to a Contractor Physician Reviewer. The Physician Reviewer assesses the information and renders a decision to authorize, call the referring physician for more information, or denies. This action must be completed in one business day (the Physician Reviewer will attempt to reach the attending physician up to three times before rendering a final decision if unable to contact within a one day time-frame).

    The following is a flowchart that shows where in Contractor's review process the right to request reconsideration occurs.

    If the decision made by the Contract Physician Reviewer is to grant authorization, the Contractor RN will enter this decision in the MDCH CHAMPS system and generate an authorization number and communicate this to the physician or their designee.

    Contractor has trained and educated some of regular PACER physician reviewers to enter their review directly into the CHAMPS' Comment Summary section.
    If the decision is to deny, the Contractor RN contacts the referring physician or their designee and informs them of the right to reconsideration. They then have 30 days to send in additional information. Case denial information is entered into the MDCH CHAMPS system. Reconsiderations must be submitted telephonically within three days of denial and followed up within 30 days of notification of denial with written supporting medical necessity documentation and a synopsis of the request/reason for reconsideration. The Contractor Physician Reviewer (like-specialty) has 30 days to respond to this reconsideration appeal. If denial upheld, the referring physician or their designee is informed verbally and in writing (The letters are State determined and in the CHAMPS system for Contractor use) that they may appeal to MDCH within 30 days. Appeals information is given to the referring provider or their designee verbally and in writing (DCH-0092 - Attachment B).

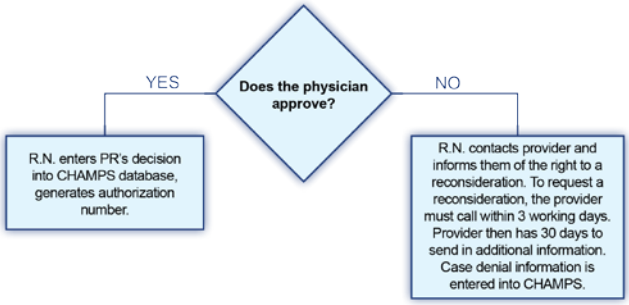
The following is a flowchart that shows where in Contractor's review process the right to request reconsideration occurs:



11. The Contractor must have a process to reconsider denials of all Inpatient PACER, VDCU Admissions and continued stays and MDCH selected DME/Medical Supply reviews at the request of the provider, practitioner or VDCU. At a minimum, the process must include all of the following:

    a. Reconsideration must be requested by the provider within three working days of receipt of the denial.

    Contractor's process includes notifying the provider of their right to request reconsideration within three working days of receipt of the denial. The RN enters this information in CHAMPS, including the date the provider was verbally notified. When the provider requests reconsideration, the date of that request is entered into CHAMPS comment section also. The following is a snippet of Contractor's process.



b. Upon written request from the provider, the Contractor must perform a reconsideration review of an adverse determination. The provider is notified, by letter, of the reconsideration decision within one business day of the receipt of the request or the date of the receipt of written documentation.

c. All reconsiderations must be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the service(s). The Contractor must complete reconsideration decisions for elective admissions (excluding rehab) and retrospective Inpatient PACER requests within 30 working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one working day of receipt of the request or the date of receipt of written documentation.

   Following a denial of a review, Contractor verbally notifies the provider that he/she has three working days to request reconsideration. Contractor also advises the provider that upon receipt of the written request to reconsider the denial, the case is reviewed by a physician of like specialty (when applicable), who is board certified and actively practicing. The physician reviewer considers all documentation supplied by the provider.

   After the reconsideration process is completed, Contractor reports all adverse determinations to MDCH.

d. The Contractor must have a two-step review process to review all denials at the request of the hospital or physician. The original request, if denied by the Contractor review coordinator (RN), goes to the Contractor physician or MDCH OMA designated physician for review. If denied, the provider is verbally told of the denial and given appeal (reconsideration) rights. The second request (reconsideration) is submitted via a Request for Retrospective Inpatient PACER Review form, (this may include a complete medical record), with a detailed description of the case including case specific information. If denied, the provider is informed verbally that they may appeal to MDCH.

   Providers can access the Retrospective Inpatient PACER Review form on Contractor's website. At reconsideration, if the denial is upheld, Contractor sends a reconsideration upheld letter that offers information on further appeal rights.

   Whenever possible, the Contractor must match the reviewing physician specialty with that of the ordering physician's specialty. After the initial denial by the subspecialty physician, the affected parties have a right to reconsideration by a second physician.

   Contractor has over 150 board certified physician reviewers that encompass all specialties. At reconsideration, we are generally able to match the Contractor physician reviewer with the ordering physician. If Contractor has an unusual physician specialty, RNs request assistance from Contractor's Medical Director. Medical Director will attempt to find a matching specialist. If requested, Contractor will expeditiously credential the physician using Contractor's expedited credentialing process or Contractor's Medical Director will recommend a specialty that is a close match.

12. If the provider requests an appeal of a denied review from the Contractor, they may appeal to MDCH. The provider is to submit the medical record for review to MDCH, OMA. OMA must review and make a

determination. Should the Contractor's denial be overturned, an Inpatient PACER number must be issued by the Contractor and communicated to the provider by the Contractor. Should the Contractor's denial be upheld by the OMA, then a letter of denial (the letters are State determined and in the CHAMPS system for Contractor use) must be sent by the Contractor. The MDCH Program Manager will notify the Contractor of the Inpatient PACER decision verbally and follow-up with a faxed memo. Provider appeals to the MDCH must be conducted so that whenever possible, multiple claim appeals from an individual provider must be heard together.

13. For inpatient rehabilitative services, inpatient stays beyond 30 days require additional inpatient authorization. The provider must contact the Contractor between the 27th and 30th days if the stay is expected to exceed 30 days. If the extended stay is approved, an Inpatient PACER authorization number is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another Inpatient PACER authorization number to the provider. In the rare event there is a need for continued inpatient rehabilitative stay(s) beyond 90 days, the provider must call the Contractor between the 87th and 90th days of stay for additional inpatient authorization. For any case not meeting admission criteria approved by the MDCH, the Contractor's nurse must refer the case to the Contractor's physician consultant. The remainder of the review and approval/denial process follows that of the Inpatient PACER review. A denial of a continued stay terminates Medicaid coverage of that hospital stay.

14. The Contractor must have the capability to access and utilize the MDCH CHAMPS system.

    Contractor's RNs who perform PACER/DME/MS/VDCU and LTC exception and LTC immediate review will have access to CHAMPS and must be extensively trained in what needs to be entered into CHAMPS for each specific review type.

15. Complete data for all requests must be individually stored and retrievable by the Contractor for seven years.

16. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract must be kept confidential and must not be provided to any third party unless disclosure is approved in writing by the MDCH.

17. The Contractor must specify the number of staff dedicated to the duties explained in this Contract and provide credentialing data prior to the start of this Contract and at the end of each year thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required.

18. The Inpatient PACER/Selected DME/MS and VDCU Admissions and Continued Stay Authorization number will be generated by the MDCH CHAMPS system.

D. Inpatient PACER, LTC Immediate Review NOTICE OF NON-COVERAGE and Long Term Care Exception Review Process

1. **Inpatient (Hospital) PACER**:
   The hospital inpatient utilization review committee may issue a notice of non-coverage (the letters are Facility determined and issued) to the patient if it determines that the admission or continued stay in the hospital or nursing facility is not medically necessary.

   A provider can choose to issue a notice of non-coverage letter, which transfers liability from Medicaid to the Medicaid beneficiary if the beneficiary chooses to stay in the hospital, unless the beneficiary requests a review from Contractor.

   Upon a request for a Notice of Non-coverage review, the RN verifies whether Contractor has previously issued an adverse determination for the period of hospitalization covered by the notice. If we have, the RN informs the beneficiary or beneficiary's representative of our concurrence with the hospital's decision.

   If Contractor has not reviewed this previously, the RN requests the medical record from the provider. Upon receipt of the medical record, the case is sent to the Contractor physician reviewer to make a determination

on whether the admission or continued stay is medically necessary. If the physician reviewer disagrees with the notice of non-coverage issued to the beneficiary, then Medicaid would continue to pay the provider for inpatient services. If Contractor's physician reviewer agrees with the provider, then Contractor would send an Adverse Action Notice to the beneficiary advising them of our concurrence with the notice. The beneficiary then has further appeal rights

If the patient or patient's representative disagrees with the notice, the patient or representative may contact the Contractor to appeal the decision. If the Contractor has previously issued an adverse determination for the period of hospitalization covered by the notice, the Contractor informs the patient or patient representative of concurrence with the hospital decision. If the Contractor has not previously issued an adverse determination for the period, a review of the medical record is conducted. The Contractor contacts the hospital to obtain a copy of the medical record. A Contractor physician advisor reviews and issues a decision on the case three days of the receipt of the final determination and the related documentation. The Contractor must provide the written decision to the beneficiary or beneficiary's representative along with the Appeal Process (DCH-0092 - Attachment B) if the Contractor agrees with the hospital provider.

If issued, the notice is the responsibility of the hospital/nursing facilities utilization review committee and is not related to any decision that may have been rendered by the Contractor on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the Contractor.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by the MDCH or an MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a department program, or delivers a service provided under a department program to a beneficiary, patient, or resident. The Michigan Administrative Hearing System (MAHS) issues timely, clear, concise, and legally accurate hearing decisions and orders. The MAHS Information on hearing procedures brochure is located on the MDCH website at http://www.michigan.gov/mdch/0,1607,7-132-2946_5093-16825--,00.html . (See also Attachment N). This website explains the process by which each different type of case is brought to completion.

2. LTC Immediate Review:

a. The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.

Contractor's Corporate Compliance Plan has detailed policies and procedures to assure confidentiality is always first and foremost priority.

b. The Contractor must provide an Immediate Review when the program/provider has issued an adverse/adequate action notice to the beneficiary based on an online Level of Care Determination (LOCD) and the beneficiary/beneficiary representative has requested an Immediate Review before noon of the first business day following receipt of the action notice. The Immediate Review is a review of the Medical record or Case file only, and not a telephonic interview with the beneficiary or the beneficiary's representative.

The LTC immediate review is a request from the Medicaid beneficiary or their representative after they have been issued an Adequate Action Notice or Advanced Action Notice by their provider.

Process Start: The beneficiary or legal representative calls our PACER toll-free telephone number to request a review (providers include this phone number on the notices).

Review Start: The RN contacts the provider and requests the medical record/case file be sent to us. Only demographic information is obtained from the beneficiary/representative.

Determination: The RN performs the review utilizing the LOCD and exception criteria to determine if the beneficiary is eligible for nursing facility LOC. The information is entered into the LOC Determination section of CHAMPS.

Findings:
Beneficiary is not eligible – Contractor agrees with the provider that the patient is ineligible for nursing facility LOC. The provider is contacted immediately and verbally informed of the decision. In addition,

Contractor's issues an Adverse or Advanced Action Notice. This notice is sent the same day as the decision. Contractor' includes the DCH Hearing Request form and an addressed stamped envelope, so the beneficiary/representative can file an appeal should they choose to do so.
Beneficiary is eligible – Contractor disagrees with the provider's determination and finds the beneficiary is eligible for nursing facility LOC. The RN notifies the provider and beneficiary by phone on the date the decision was made.

c. The Contractor's clinically experienced RN must provide Immediate Reviews of the medical record or case file upon request of the ineligible beneficiary/beneficiary representative as follows:
   i. Clinically experienced RNs must receive the Immediate Review request by telephone or in writing from the beneficiary/beneficiary's representative and must perform, at a minimum, all of the following:

      - Elicit all relevant medical documentation (medical records from the past 60 days from the date of the request for the Immediate Review, including physician and nursing progress notes, skilled therapy notes, plan of care, physician orders and logs identifying risk, services or therapy days, and the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver);

   ii. Complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination which includes all of the following:
      aa. Exception or Immediate Review
      bb. Provider Call Date and Time
      cc. Nurse Review Coordinator Identification (NRC ID)
      dd. Information Summary
      ee. Determination Date and Time
      ff. Review Coordinator (RC ID
      gg. Denial Upheld or Approved
      hh. Approval Code (if Approved)
      ii. LTC Adequate Action or Advance Action Notice Date (if Denied) (Attachment C-D)

   iii. Reach a determination based on current Nursing Facility Level of Care Exception criteria within three business days of receiving medical documentation;

   iv. Notify the provider and the ineligible beneficiary of the Immediate Review determination on the date of the determination:
      aa. A determination of 'ineligibility' must be issued in writing to the beneficiary/beneficiary's legal representative by way of an adequate or advanced action notice. The notices must include appeal rights. An appeals form (DCH-092 Hearing Request – Attachment B) provided by the State must accompany the adequate and advanced action notices.
      bb. A determination of 'ineligibility' must be issued to the provider telephonically within three business days of receiving medical documentation.
      cc. A determination of 'eligibility' must be issued telephonically to the beneficiary/beneficiary's legal representative and to the provider within three business days of receiving medical documentation.

   v. The Contractor must maintain a toll-free telephone number for providers/programs and beneficiaries to request an Immediate Review. The Contractor must answer all incoming phone calls with an average time of 90 seconds or less.

      Providers put Contractor's toll-fee PACER phone number on the Adequate Action Notice and Advanced Action Notices, so Medicaid beneficiaries can contact Contractor for an immediate review.

d. The Contractor must not perform an Immediate Review under the following conditions:
   i. An Exception Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;

   ii. An ineligible Michigan Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;

iii. If the provider has not issued an adequate or advanced action notice to the beneficiary/beneficiary's legal representative;

iv. If the MI Choice Waiver program participant has received an adequate action notice addressing **only the suspension or reduction of MI Choice Program services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;

v. If the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

E. Long Term Care Exception Review

1. The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.

   Contractor's Corporate Compliance Plan has detailed policies and procedures to assure confidentiality is first and foremost priority.

2. The Contractor's clinically experienced RN must provide telephonic Exception Reviews upon request of the provider/program who has determined the beneficiary to be ineligible as follows:
   a. Clinically experienced RNs must receive the Exception Review request(s) by telephone. The Contractor must answer all incoming calls promptly with average time to answer of less than 90 seconds;

      Contractor's toll-free telephone system is automated. When the provider or beneficiary calls our toll-free phone number, they hear a message that lets them know who they have reached. The call is then sent to the first available RN. If all the RNs are on a call, the caller is placed in a queue and as soon as a RN is available the caller is routed to that RN.
      This process begins when the RN answers the call, (s)he asks the caller the purpose of their call. When it is determined that the case is an exception review, the RN goes into CHAMPS and selects LOC Determination.
      (S)He asks the caller questions related to frailty, behavior, and complex medical conditions to determine if the beneficiary meets eligibility criteria under the exception criteria.

      MDCH EXCEPTION CRITERIA
      Frailty
      The beneficiary has a significant level of frailty as demonstrated by at least one of the following categories:
      - Applicant demonstrates late loss Activities of Daily Living (ADLs) (i.e., bed mobility, toileting, transferring, and eating);
      - Applicant performs ADLs independently, but requires an unreasonable amount of time;
      - Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity;
      - Applicant has experienced at least two falls in the home in the past month;
      - Applicant continues to have difficulties managing medications despite the receipt of medication set-up services;
      - Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services; and
      - Applicant meets criteria for Door 3 when ER visits for clearly unstable conditions are considered.

      Behaviors
      The beneficiary has at least a one-month history of any of the following behaviors and has exhibited two or more of these behaviors in the past seven days:
      - Wandering;
      - Verbal or physical abuse;
      - Socially inappropriate behavior; or
      - Resists care.

      Treatments
      The beneficiary has demonstrated a need for complex treatments or nursing care.

Based on the what the caller reports in response to the questions the RN asks, the RN determines if the beneficiary is eligible or ineligible for nursing facility LOC under the exception criteria.
If the RN finds the beneficiary ineligible, (s)he sends the beneficiary an Adverse Action or Advanced Action Notice which includes their right to appeal. Enclosed in the letter is the DCH-Hearing Request form and an addressed stamped envelope.

b. The Exception Review must include all of the following medical information:
   - All relevant medical information, verbally (medical information from up to the last 60 days from the date of the exception review request, which may include physician and nursing progress information, skilled therapy information, plan of care, physician orders and logs identifying risk, services or therapy days, and information from the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver).

     When the RN talks to the caller, (s)he asks for all relevant medical information. This task is performed verbally, so the RN asks, "What does the MDS or MDS-HC say regarding transfers?" or "What treatments are being provided to this beneficiary. What do the orders say? What does the progress note or nursing note say regarding that?" With the training the RNs have in LOC Determination exception review, their clinical expertise, and what they are able to retrieve from the caller, the RNs get a good understanding of the beneficiary and the beneficiary's LOC needs.

c. Complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination:
   i. Exception or Immediate Review
   ii. Provider Call Date and Time
   iii. NRC ID
   iv. Information Summary
   v. Determination Date and Time
   vi. RC ID
   vii. Denial Upheld or Approved
   viii. Approval Code (if Approved)
   ix. LTC Adequate Action or Advance Action Notice date (if denied) see Attachment C-D

d. Reach a determination based on current Nursing Facility Level of Care Exception criteria within 24 hours of the provider/program's call date/time;

   Contractor performs this review in real time, which means generally the decision is made by the RN while on the phone with the provider.

e. Notify the provider of the Exception Review determination telephonically on the date of the determination:
   i. A determination of 'ineligibility' must be issued to the Provider telephonically.
   ii. A determination of 'ineligibility' must be issued in writing to the beneficiary/beneficiary's legal representative by way of an adequate or advanced action notice. The notices must include appeal rights. An appeals form (DCH-092 Hearing Request – Attachment B) provided by the State must accompany the adequate and advanced action notices.

   Contractor's RN notifies the provider at the time of intake that the beneficiary is eligible or ineligible for nursing facility LOC. Notification in writing is sent to the beneficiary if Contractor finds the beneficiary ineligible. The RN sends the beneficiary an Adequate Action or Advanced Action Notice which includes their right to appeal. Enclosed in the letter are the DCH Hearing Request form and an addressed stamped envelope.

f. The Contractor must maintain a toll-free telephone number for providers/program to request a telephonic Exception Review. The Contractor must answer all incoming phone calls with an average time of 90 seconds or less.

Contractor's toll-free telephone system is automated. When the provider or beneficiary calls Contractor's toll-free phone number, they hear a message that lets them know who they've reached. The call is then routed to the first available RN. If all the RNs are on a call, the caller is placed in a queue and as soon as a RN is available the caller is routed to that RN. .

3. The Contractor must not perform an Exception Review under the following conditions:
   a. An Immediate Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;

   b. An ineligible Michigan Medicaid Nursing Facility LOCD does not exist in the online database for the same beneficiary under the same provider/program;

   c. If the MI Choice Waiver program is addressing **only** the **suspension** or **reduction** of MI Choice Program **services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;

      If the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

F. Appeals Process for Inpatient PACER and Long Term Care (Immediate) Review

1. **Inpatient PACER Appeals:**
   Only after the internal Contractor's appeals have been exhausted may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor must provide the written reports and make direct testimony available to the MAHS as the MDCH deems necessary.

   The MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules MAC (R400.3401-400.3425) under the authority conferred on the Director of the MDCH by Sections 6 and 9 of Act No. 280 of the Public Acts of 1939. The Contractor must provide sufficient staff including RNs/Physicians for participation and testimony in the MDCH appeals process. This involvement must begin at the Bureau Conference level and continue as required through the Administrative Law Judge (ALJ) level or until the provider has accepted a final decision of the case.

   The Contractor will make decisions that may result in an appeal to the State. The Contractor must notify the Medicaid beneficiary in writing of any adverse action, i.e., denial, reduction, or termination of services and their appeal rights, when such denial, reduction, or termination results from the PA process (outlined above). The Department's Administrative Manual, Hearings and Appeals Section, contains the MDCH's policies and procedures regarding administrative hearings. The Contractor must comply with this policy and all relevant federal regulations and State statutes. The Contractor must prepare the hearing summary for all requests for hearings involving FFS beneficiaries covered by this Contract. The Contractor is solely responsible for presenting its position at the beneficiary's administrative hearing. The Contractor must present the hearing summary and testify at all hearings involving the Department's FFS beneficiaries covered by this Contract.

   All notifications explain the reason for the denial and include a DCH Request for Hearing form and an addressed stamped envelope.
2. **Long Term Care Appeals:**
   Beneficiary Appeals

   An ineligible beneficiary may appeal directly to the MDCH, and/or request an Immediate Review from the Contractor after an adverse/adequate action notice has been issued by the provider within the guidelines stated in the provider's adverse/adequate action notice. When an MDCH appeal is made, the Contractor must provide the written reports and make direct testimony available to the MDCH as the MDCH deems necessary.

   The provider/program may request an Exception Review on behalf of the ineligible beneficiary. The adverse/adequate action notice must not have been issued to the ineligible beneficiary. If the adverse/adequate notice was issued, then the beneficiary has the right to request an immediate review. If an Exception Review was conducted by the Contractor, then an Immediate Review may not be conducted by the Contractor if the Immediate Review is for the same beneficiary's LOCD for the same period.

   The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all PA/Immediate and Exception Review requests including the adverse and adequate action notice. The Contractor must send an adverse/adequate action notice to all persons determined ineligible by the Contractor based on the Immediate or Exception review criteria who were seeking Medicaid coverage in one of the above listed FFS Long Term Care Programs utilizing the appropriate denial statement.

In addition to the telephonic request, providers or beneficiaries can fax a request to Contractor's review team. The fax number is dedicated only to that team. Providers can also send/receive information via the DCH file exchange in CHAMPS. When Contractor determines a beneficiary is ineligible based on the immediate or exception review criteria, Contractor sends the applicable letter (Adequate Action Notice or Advanced Action Notice) to the beneficiary. The MDCH Medicaid Provider Manual explains the differences in the notices. The Adverse Action Notice is used for new applicants determined ineligible; whereas, the Advanced Notice is used for current program participants. Contractor sends the notices to the beneficiary/legal representative by USPS.

An appeals form (DCH-092 Hearing Request) and addressed stamped envelope provided by the State must accompany the adverse/adequate action notice. The adverse/adequate action notice and appeal form must be sent to the beneficiary or the beneficiary's legal representative on the day of the adverse/adequate action. Copies of all adverse/adequate action notice must be stored by the Contractor for seven years and be available upon request.

G. Long Term Care Retrospective Review

1. **Long Term Care Retrospective Review Requirements:**
The Contractor must maintain absolute confidentiality of providers and beneficiary's assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract must be kept confidential and must not be provided to any third party unless disclosure is approved in writing by the MDCH.

The Contractor must perform the Retrospective reviews from a statistically valid random sample as generated by the MDCH. The review sample must contain the following:
a. Provider's Medicaid ID/NPI Number
b. Beneficiary's name
c. Beneficiary's Medicaid ID
d. Beneficiary's date of birth
e. Date the online Michigan Medicaid Nursing Facility Level of Care was created
f. Door through which the beneficiary qualified

On a monthly basis, MDCH sends Contractor a selection. The selection is uploaded into Contractor's database.
Once the required information is uploaded into the database, Contractor's Administrative Assistant processes the medical record request letters. The letters are sent by USPS to the selected providers. The provider has 30-calendar days to submit the medical record.

The Retrospective review sample will be given to the Contractor by the MDCH. The Contractor must inform the nursing facility MI Choice Waiver provider or PACE organization of a Retrospective review by way of Notification of Retrospective Review letter (see Attachments E, F, and G). The letter must include the Medicaid ID(s) of the beneficiary(s) who will receive a Retrospective Review, the 'to' and 'from' dates that the Contractor will be reviewing, and a list of the medical records required from the provider/program by the Contractor, as well as the date by which the requested medical records must be received by the Contractor in order to conduct the Retrospective review.

The provider/program has 30 calendar days from the date of the Contractor's Notification of Retrospective Review letter to respond by way of receipt of all requested medical records to the Contractor. The Contractor has 30 calendar days from the date the full medical records are received from the provider/program to complete the Retrospective Review. When an incomplete set of medical records is received by the Contractor from the provider/program, the Contractor must begin the review of the medical records submitted. Retrospective Reviews must be conducted at the Contractor's place of business.

Should the provider/program not respond, or respond with an incomplete set of requested medical records, to the Contractor's Notification of Retrospective Review letter within 30 calendar days from the date of the

request, the Contractor must issue an Incomplete Retrospective Review – Medical Record Submission Reminder letter (see Attachment H).

Should the provider/program not respond to the request in the Incomplete Retrospective Review – Medical Record Submission Reminder letter within 15 calendar days from the date the Incomplete Retrospective Review – Medical Record Submission Reminder letter was sent, the Contractor must issue a Retrospective Review Final Technical Denial letter to the provider/program (see Attachment I).

This information is entered into Contractor's database.
The Contractor must forward to the MDCH a recommendation for Retrospective Review Final Technical Denial with the monthly reports.

The Contractor must send, to each provider for whom a Retrospective Review was conducted, a Retrospective Review Determination letter (see Attachment J, K, and L), informing the provider/program of the result of the Contractor's Retrospective Review for each case review.

a. Nursing Facility Retrospective Review Process:
   The Contractor must request from the Nursing Facility provider copies of the beneficiary's medical records for the 90 day period under Retrospective Review as follows:
   i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
   ii. Copy of the **Signed** Computer Generated Freedom of Choice Form or a copy of the **Signed** Hard Copy of Freedom of Choice form attached to the Computer-Generated Freedom of Choice form
   iii. PASARR screen Level I
   iv. PASARR screen Level II, if indicated by PASARR screen Level I
   v. MDS documents
   vi. Nursing notes
   vii. Physician notes
   viii. Interdisciplinary Care Plan notes
   ix. Quarterly Care Planning notes
   x. Skilled therapy evaluations and progress notes
   xi. Discharge plans
   xii. Medicare Certification/Recertification form

The Contractor must review the medical records based on the following criteria:
   i. Medical necessity for admission based on the Michigan
   ii. Medicaid Nursing Facility Level of Care Determination
   iii. Continued stay criteria based on the Michigan Medicaid
   iv. Nursing Facility Level of Care Determination

Contractor determines medical necessity for admission and continued stay based on documentation in the medical record/case file and evaluates it with the LOC Determination criteria. RNs assure the Door the provider/program determined eligibility under is supported by the documentation in the medical record. If the documentation does not support the Door the provider/program determined the beneficiary was eligible under, the RN will see if the beneficiary qualifies under another Door. If not, the RN will evaluate the documentation against MDCH's Exception criteria.

The Contractor must report their findings to the MDCH LTC Program Manager on a monthly basis. Findings must include the number of Retrospective Reviews in which the Contractor agreed with the provider's door of eligibility, the number in which the Contractor agreed with the eligibility in general, the number in which the Contractor disagreed (denial), the number of Retrospective reviews resulting in a Retrospective Review Final Technical Denial, and the number of Retrospective Review Final Technical Denials based on the absence of PASARR documentation. The Contractor must also report on the number of outstanding Nursing Facility Retrospective reviews, the number of Retrospective Reviews conducted to date and their findings.

b. MI Choice Waiver and PACE Retrospective Review Process:

The Contractor must request from MI Choice Waiver program providers copies of the beneficiary's medical record (case record) for the 90 day period under retrospective review, as follows:

i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
ii. Copy of the **Signed** Computer-Generated Freedom of Choice form or a copy of the **Signed** Hard Copy Freedom of Choice form attached to the Computer-Generated Freedom of Choice form
iii. MDS-Home Care Assessment or PACE Minimum Data Set assessment documents
iv. Medical Notes
v. Physician Notes and Orders
vi. MI Choice Waiver or PACE contact notes from friends, family of the enrollee, or from the enrollee
vii. MI Choice Waiver or PACE participant's Plan of Care

The Contractor must review the records based on the following criteria:

i. Medical necessity for enrollment based on the Michigan Medicaid Nursing Facility Level of Care Determination
ii. Continued program participation based on the Michigan Medicaid Nursing Facility Level of Care Determination

Contractor's RNs determine medical necessity for enrollment and continued program participation based on documentation in the case file and compares the documentation to the LOC Determination criteria. RNs assure that the Door the provider/program determined eligibility under is supported by the documentation in the case file. If the documentation does not support the Door the provider/program determined the beneficiary was eligible under, the RN will see if the beneficiary qualifies under another Door. If not, the RN will evaluate the documentation against MDCH's Exception criteria.

The Contractor must report their findings to the MDCH LTC Program Manager on a monthly basis. Findings must include the number of Retrospective Reviews in which the Contractor agreed with the program's door of eligibility, the number in which the Contractor agreed with eligibility in general, the number in which the Contractor disagreed (denial), the number of Retrospective Reviews resulting in a Retrospective Review Final Technical Denial, and the number of Retrospective Review Final Technical Denials based on the absence of PASARR documentation.

H. Appeals Process for Long Term Care Retrospective Review

Long Term Care Retrospective Review:

a. Provider Appeals

The Contractor must send Retrospective Review Denial recommendations to the MDCH following the completion of the Contractor's Retrospective review. The Contractor must send notice of the determination of the Retrospective Review(s) to the provider/program. The provider/program must be able to request reconsideration (appeal) of any adverse/adequate determination made by the Contractor for admission or extended stay within three working days of receipt of the adverse/adequate determination. The MDCH allows the provider the right of appeal through the Medicaid Provider Manual and the Medicaid Provider Reviews and Hearings Administrative Rules, MAC R400.3401-400.3425 under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939.

The Contractor's nurse reviewer and a like specialty physician (when applicable) must be available to testify as to the results of the Retrospective Review at any preliminary or bureau conference, administrative hearing, or judicial proceeding. The Contractor physician representation at the appeals will be at the request of the MAHS for the MDCH.

b. Beneficiary Appeals

Beneficiaries as well as providers/programs have the right to appeal a denial of service. As is the case for Medicare, beneficiary appeals made during the inpatient stay must be resolved by the Contractor within three working days. Appeals made to the Contractor following discharge must be resolved within 30 working days.

Only after these appeals have been exhausted, may any appeal be made directly to the MAHS/MDCH. When such an appeal is made, the Contractor must provide the written reports, and make direct testimony available to the MAHS/MDCH as the MDCH deems necessary.

An appeals form (DCH-0092 Hearing Request – Attachment B) and an addressed stamped envelope provided by the State must accompany the adverse/adequate action notice. The adverse/adequate action notice and appeal form must be sent to the beneficiary the day of the adverse/adequate action. Copies of all adverse/adequate action notice must be stored by the Audit Contractor and available upon request.

Contractor's RNs send out the notice the day Contractor makes the adverse determination. Contractor saves and stores these letters electronically for seven years.

I. Additional Contractor Requirements

a. The Contractor must maintain all reporting requirements established by the MDCH.

b. The Contractor must maintain a positive working relationship with Providers of medical care and Provider Organizations

c. The Contractor must maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. The Contractor's Project Manager and staff must have an office located in the Greater Lansing area.

e. The Contractor must be a Peer Review Organization (PRO). However, Quality Improvement Organization (QIO)-like entities also satisfies the requirements of the Contract and are qualified for this Contract as well.

Contractor is designated by CMS as a QIO-like entity, with a 5-year certification effective through June 4, 2019. In 2019, Contractor will resubmit documentation for an additional term of certification.

1.2 Transition

For the Contract, the following mechanisms must be in place:

1. Readiness for Implementation

a. The Contractor must have an operational system in place no later than the first day of this Contract including, but not limited to, sufficient staff.

Contractor is currently operational and will be ready with sufficient staff on the first day of this contract. The people who currently work on the contract all have access to CHAMPS and are all trained in utilization review and in LTC LOC determination, exception review criteria, and Medicaid policy.

b. The Contractor must demonstrate to the MDCH's satisfaction, no later than one month from the startup of the Contract, that the Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:
   i. A sufficient number of RNs and Physicians experienced in the areas of Inpatient PACER, selected DME/MS, VDCU Admissions/continued stays and LTC, and physician's experienced in the area of LTC, to perform the review duties as specified herein. The RNs performing the LTC review functions cannot perform the Inpatient PACER authorizations. The MDCH expects the Contractor to designate separate staff for each review.
   ii. The Contractor has thoroughly trained its staff on the specifics of the Inpatient PACER, selected DME/MS, VDCU Admissions/continued stays and LTC review processes and that the Contractor's staff has knowledge to make determinations of medical services needed.
   iii. The Contractor has the ability to accept, review, and utilize the CHAMPS system for documentation of Inpatient PACER, selected DME/MS, VDCU Admissions/continued stays and LTC reviews that have been completed.
   iv. The Contractor has quality assurance procedures in place that assures it follows all State and federal laws for confidentiality.

c. The Contractor's inability to demonstrate to the MDCH's satisfaction and as provided herein, that the Contractor is fully capable of performing all duties under this Contract no later than the start-up of the Contract (i.e. January 1, 2015), including, but not limited to staff, will be grounds for the immediate termination of this Contract by the State in accordance with the terms specified herein.

2. Program Specification

a. The Contractor must complete the review process within the Timeframes described in the Contract and submit the required reports within the Timeframes described in the contract.

b. The Contractor must retain all records until the review is closed and the seven year retention period has been met or the records are requested by the Appeals Section.

Fraud and Abuse

The Contractor must report suspected fraud, and/or abuse by Medicaid beneficiaries and/or providers to the Office of Health Services Inspector General (OHSIG). The report must detail the provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located at www.michigan.gov/fraud.

Contractor

1.3 Training

Contractor must have a rigorous training program for RNs coming into Contractor's PACER/DME/MS/VDCU and LTC immediate and exception review programs. As with any training program, the PACER Manager assesses what the RN already knows (e.g., InterQual® criteria, CHAMPS, LOC Determination criteria, etc.). Once the manager's assessment is made, the training consists of the following:

Week 1: The new RN reviewer sits with a trained PACER RN reviewer for one week. They share a dual headset (training headset), so the new RN reviewer can hear what the experienced RN reviewer is asking and what the caller is reporting. The new RN reviewer is also watching entry into CHAMPS and the use of InterQual®. During any down times, the RN works on a web-based training on the use of InterQual®.

Week 2: One-on-one training with an experienced RN on CHAMPS entry. Initially, it is only for readmissions, elective admissions, rehabilitation admissions, and transfers. The new RN continues on their own time to review InterQual® criteria. At defined times, the new RN continues to sit with an experienced RN and listen to incoming/outgoing calls.

Week 3: Using dual headsets, the new RN enters information into CHAMPS, while the experienced RN asks the questions. The new RN also applies InterQual® criteria.

Week 4: The new RN and the experienced RN are attached to dual headset, but the new RN handles the calls on his/her own, unless help is needed.

Week 5-8: The new RN continues to gain experience, essentially on his/her own, with an assigned mentor.

Week 8: The new RN begins training on DME/MS/VDCU reviews, including CHAMPS entry and Medicaid policy.

Week 12: The manager determines if the new RN is ready to be trained on the LTC exception/immediate review. If so, training begins. Any time a call is received, the new RN and experienced RN use dual head phones, so the new RN can learn the questions asked and how to use the criteria. (S)He is also being trained on entering into MDCH's online LOC Determination.

Retrospective LOC Determination review is similar. The RN needs to be very familiar with the LOC determination criteria and PASARR, Freedom of Choice, MDS, etc. We assign a mentor to the new employee/RN for approximately three months to see the entire process through.

Upon request from the MDCH Program Manager, the Contractor must provide all documentation and training materials that are used to train the Contractor's staff to perform the Contract Activities.

1.4 Contract Activities that will Include IT Related Services. The Contractor must utilize the MDCH CHAMPS.

2.0 Acceptance

2.1 Acceptance, Inspection and Testing
The State will use the following criteria to determine acceptance of the Contract activities:

The Program Manager will monitor that the Contractor completes work within the timeframes listed in the Contract. MDCH Program Managers will provide additional training, on an as-needed basis, on-site (either at Contractor's site or at a State site), by email, by facsimile, or by telephone conference calls regarding Medicaid policy, Medicaid policy interpretation and/or additional education necessary for the Contractor to perform proper review.

1. **Inpatient PACER, Selected DME/MS and VDCU Admissions and Continued Stays**:
   The MDCH Program Manager will review the following data: number of cases reviewed; number review coordinator approved, number referred, and number denied; number physician approved, and denied; number reconsideration cases; number reconsideration overturned and upheld; net denials number and percent of denials; number of abandoned calls, number of Inpatient PACER, Selected DME/MS and VDCU Admissions/Continued Stay calls. The Program Manager will also review that the date and time of the request, approval, or denial was within the timeframes specified in the Contract.

2. **LTC Exception and Immediate Reviews:**
   The MDCH LTC Program Manager will review the following data submitted by the Contractor in the Immediate/Exception Review Report: number of Immediate and Exception Reviews performed per month, the number denied, number approved and the approval code.

   The Program Manager will also review that the date and time of the request, approval, or denial was within the timeframes specified in the Contract.

3. **LTC Retrospective Review:**
   The MDCH LTC Program Manager will also review the following data submitted by the Contractor in the Retrospective Review reports: the number or retrospective reviews performed per month; the number upheld, the number overturned (final denial),and the number of technical denials; the number of technical denials based on an incomplete medical record/case record, the number of technical denials based on the absence of PASARR documentation; and the number of abandoned calls.

   The MDCH LTC Program Manager will review LTC reports as defined in Section 4.3 – Reports. Reports must be transmitted electronically or by mail to the MDCH in compliance with HIPAA transactions.

3.0 Staffing

3.1 Contractor Representative
1. The Contractor must appoint one RN Contractor Representative, specifically assigned to State of Michigan accounts, who will respond to State inquiries regarding the Contract activities, answering questions related to the Contract (the "Contractor Representative"). Also see Section 3.5 – Key Personnel.

Melody Petrul, Director of Medical Review Services, will serve in this role upon contract award.

Role – Manages Contractor's Review Program and serves as the primary point-of-contact for MDCH related to all contract activities.

2. The Contractor must notify the Contract Administrator at least 30 calendar days before removing or assigning a new Contractor Representative.

3.2 Customer Service Toll-Free Number
1. The Contractor must specify its toll-free number for the State to make contact with the Contractor Representative.

Contractor's toll-free number is 1-800-727-7223.

2. The Contractor Representative must be available for calls during the hours of 8:00 a.m. to 5:00 p.m. EST Monday through Friday except for State approved/sanctioned holidays.

3.3 Reserved

3.4 Work Hours

The Contractor must provide contract activities during the State's normal working hours Monday through Friday 8:00 a.m. to 5:00 p.m. EST except for State approved/sanctioned holidays.

3.5 Key Personnel

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

   Contractor is designating Yvonne Kendall, RN, BSN as the Contractor Representative who will be directly responsible for the day-to-day operations of the contract. Ms. Kendall oversees is responsible for the following case review:
   - Elective inpatient hospital admissions
   - Readmissions within 15 days
   - Inter-hospital transfers
   - Non-prospective payment system rehabilitation unit admissions and continued stays
   - Enteral (oral and tube feeding over 3,000 calories) and TPN
   - Intravenous Infusion Therapy
   - Negative Pressure Wound Therapy
   - Home Uterine Activity Monitors
   - Ventilator Dependent Care Units
   - Long Term Care Admission and Continued Stay

2. It is required that the phone lines be staffed by RN's.

3. Other Contractor Key Personnel in addition to the above mentioned RN Contractor Representative (i.e. RN Reviewers and Physician Reviewers – both in house physicians and contracted specialty physicians - that perform the day-to-day review activities) follow:

   A. OVERVIEW
   Contractor's nurse review team are licensed RNs in the State of Michigan and are knowledgeable of PACER/DME/MS/VDCU utilization review/LTC.
   The PACER RN Reviewers are located in Contracto's Farmington Hills, Michigan office.

   B. PACER RN Reviewer
   Role – Assures the care and services provided to Medicaid beneficiaries is medically necessary and performed in the appropriate setting and in accordance with state and federal guidelines.

   C. PACER RN Reviewer
   Role – Assures the care and services provided to Medicaid beneficiaries is medically necessary and performed in the appropriate setting and in accordance with state and federal guidelines.
   Contractor

   D. LTC Retrospective Reviewer
   Role – Works with the RNs and support staff to assure the LTC retrospective review is performed in accordance with state requirements. This RN performs retrospective LTC review.
   Contractor

   E. LTC Retrospective Reviewer
   Role – Performs retrospective LTC reviews and provides consistent and reliable reporting.

   F. Medical Director – James C. Mitchiner, MD, MPH, FACEP
   Role – Serves as a physician reviewer for the inpatient and outpatient/ER audits, as needed to assist the nurse reviewers. Participates in hearings and appeals at MDCH as needed.

   G. PHYSICIAN REVIEWERS

Contractor's professional review network is comprised of more than 150 licensed, board-certified, and credentialed physicians. We have experienced physician reviewers representing the entire spectrum of medical specialties and subspecialties.
Physician reviewers are knowledgeable of local standards of care for peer-to-peer review activities and Medicare and Medicaid principles, and are experienced in nursing care and utilization review procedures. Specifically, physician reviewers are experts in:

- Inpatient/outpatient hospital/ER services/PACER/utilization review;
- LTC and Michigan's Medicaid criteria; and
- Inpatient hospital admission criteria approved by MDCH and nursing facility LOC exception criteria.

At the reconsideration level, Contractor sends cases to the same specialty physician as the physician who provided the care. In addition, Contractor keeps physician reviewers abreast of current trends and changes in Medicare and Medicaid principles through quarterly education sessions, newsletters, and hands-on training.

They also have current knowledge and clinical experience, have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity and have no conflicts-of-interest with any case under review. These physicians maintain active medical practices while participating in our medical review processes and/or committee activities. More than 25 of our physician reviewers are also board-certified from the American Board of Quality Assurance and Utilization Review Physicians.

4. Contractor's RN Contractor Representative (or equally qualified RN personnel - to be identified in times of replacement of the RN Contractor Representative) must be on-site at Contractor's main office during the following times: 8:00 a.m. to 5:00 p.m. EST Monday through Friday.

5. The Contractor must specify the number of staff dedicated to the duties explained in this Contract and provide credentialing/licensure prior to the start of this Contract.
    a. Attestation of licensure will be required at the end of each year thereafter.

    b. In addition, proof of licensure must be sent to the State at time of hire for all new employees where licensure is required.
    c. The RN Reviewers must report directly to the Contractor Representative (an RN) who must report directly to an RN.

    d. Necessary substitutions due to change of employment status and other unforeseen circumstances must be made with PA to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure PA is required by the MDCH. Necessary substitutions to change of employment status and other unforeseen circumstances will be made with MDCH's prior approval. If a replacement doesn't have the same licensure, Contractor will seek MDCH's approval to change the status.

6. The Contractor must utilize RN Reviewers who demonstrate knowledge of Inpatient PACER authorization utilizing McKesson ® Interqual criteria and demonstrate knowledge of selected DME/MS and VDCU Admissions/continued stays using Michigan Medicaid policy specifications.
    a. The Contractor must utilize Registered Nurse reviewers for LTC Immediate, Exception, and Retrospective Reviews who demonstrate knowledge of LTC and Michigan's Medicaid criteria.
    b. The Contractor must utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient Hospital admission criteria approved by MDCH and Nursing Facility Level of Care Exception criteria.
    c. The Registered Nurses performing the LTC Immediate and Exception review functions cannot perform the Retrospective Review and Inpatient PACER authorizations, MDCH expects the Contractor to designate separate staff for each.

7. The Contractor must be staffed by Physician Reviewers with expertise in the areas listed above and expected to act as a resource in the Inpatient PACER authorization process, selected DME/MS, VDCU Admissions/ continued stays and, when requested by the ALJ, participate in appeal representation for these areas as well as LTC Retrospective Review appeals. The Contractor must also retain subspecialists for use in the reconsideration process.

8. 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 must notify the State of the proposed assignment, introduce the individual to

the State's Program Manager, and provide the State with a résumé, RN/Physician Licensure 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-calendar day training period for replacement personnel.

9. 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.

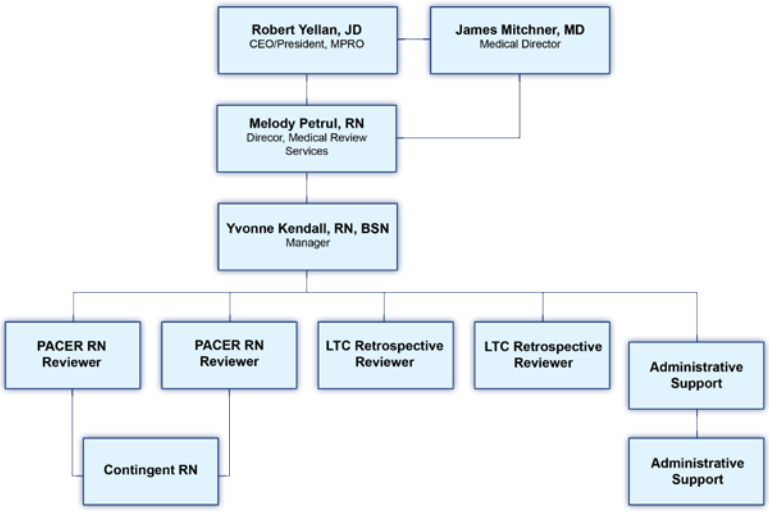
10. It is further acknowledged that an Unauthorized Removal will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any Unauthorized Removal. Therefore, Contractor and the State agree that in the case of any Unauthorized Removal in respect of which the State does not elect to exercise its rights under Termination for Cause, Contractor will issue to the State the corresponding credits set forth below (each, an "Unauthorized Removal Credit"):

    (i) For the Unauthorized Removal of any Key Personnel designated in the applicable Statement of Work, the credit amount will be $25,000.00 per individual if Contractor identifies a replacement approved by the State and assigns the replacement to shadow the Key Personnel who is leaving for a period of at least 30 calendar days before the Key Personnel's removal.

    (ii) If Contractor fails to assign a replacement to shadow the removed Key Personnel for at least 30 calendar days, in addition to the $25,000.00 credit specified above, Contractor will credit the State $833.33 per calendar day for each day of the 30 calendar-day shadow period that the replacement Key Personnel does not shadow the removed Key Personnel, up to $25,000.00 maximum per individual. The total Unauthorized Removal Credits that may be assessed per Unauthorized Removal and failure to provide 30 calendar days of shadowing will not exceed $50,000.00 per individual.

    Contractor acknowledges and agrees that each of the Unauthorized Removal Credits assessed above: (i) is a reasonable estimate of and compensation for the anticipated or actual harm to the State that may arise from the Unauthorized Removal, which would be impossible or very difficult to accurately estimate; and (ii) may, at the State's option, be credited or set off against any fees or other charges payable to Contractor under this Contract.

3.6 Organizational Chart



3.7 Disclosure of Subcontractors
If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

1. The legal business name; address; telephone number; a description of subcontractor's organization and the services or Contract Activities 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. Of the total Contract, the price of the subcontractor's work.

3.8 Security
The Contractor's staff may be required to make deliveries to or enter State facilities. In the rare event that this happens, the State may require the Contractor's personnel to wear State issued identification badges.

4.0 Project Management

4.1 Project Plan
The Contractor will carry out this project under the direction and control of the Program Manager. Within 30 calendar days of the Effective Date, the Contractor must submit a project plan to the Program Manager for final approval if required. The plan must include: (a) the Contractor's organizational chart with names and title of personnel assigned to the project, which must align with the staffing stated in accepted proposals; and (b) the project breakdown showing sub-projects, tasks, and resources required.

4.2 Meetings
The Contractor must permit the MDCH or its designee to visit and to make an evaluation of the project as determined by the Program Manager. At least once per Contract year, the MDCH will complete a site visit of the Contractor to monitor work in progress. The monitoring will occur at the Contractor's site. All travel, lodging, and meal expenses for up to three State of Michigan employees must be paid by the Contractor for this yearly review.

The Contractor must meet/teleconference with the MDCH Contract management at least every other week during the first month of the Contract and at least every other month for the remainder of the Contract to review all reports, discuss issues, etc.

The State may request other meetings, as it deems appropriate.

4.3 Reporting

The MDCH reserves the right to adjust the number of Inpatient PACER, Selected DME/MS, VDCU Admissions and Continued Stays, and LTC Retrospective reviews with a 30 day notice to the Contractor. The State reserves the right to change/cancel the review process.

1. Reports and information must be submitted to the MDCH Program Manager at the address listed in this Contract. The Program Manager will evaluate the reports submitted as described in this section for their completeness and adequacy.

2. Inpatient PACER, Selected DME/MS, VDCU Admissions and Continued Stays Reports:

Reports must be provided electronically to the MDCH Program Manager monthly, quarterly and annually by the fifth calendar day following the timeframe (monthly, quarterly, or annually) that services were rendered. They must include: number of cases reviewed; number review coordinator approved, number referred, and number of cases denied; number of cases physician approved, and denied; number of reconsideration cases; number of reconsideration cases overturned and upheld; number of net denials and percent of denials; number of cases appealed, number of appealed cases overturned and upheld.

The Contractor must report, by percentage and whole numbers, all telephone calls where the provider remains on hold greater than 90 seconds.

The Contractor must report, by percentage, the numbers of calls not completed in a timely manner.

3. LTC Immediate and Exception Review Reports:

Reports must be provided electronically or by mail to the LTC Program Manager monthly, quarterly, and annually. For Immediate and Exception Reviews, they must include:

a. Number of Exception Reviews and Immediate Reviews Performed.
b. The following information for each Immediate and Exception Review:
   i. Telephone contact date from the provider/beneficiary/representative
   ii. Review determination date
   iii. Beneficiary's first and last name and Medicaid ID
   iv. Providers NPI and setting type (nursing facility, waiver, PACE)
   v. Review Nurse's initials
   vi. Number approved and the approval code
   vii. Number denied
   viii. Copies of Immediate and Exception Review Adverse and Adequate actions
   ix. Copies of the documentation reviewed in Immediate Reviews
   x. Number of Immediate and Exception Reviews appealed

The Contractor must report, by percentage and whole numbers, all telephone calls where the provider remains on hold greater than 90 seconds.

The Contractor must report, by percentage, the numbers of calls not completed in a timely manner.

4. LTC Retrospective Review Reports:

Reports must be provided electronically or by mail to the LTC Program Manager monthly, quarterly and annually. LTC Retrospective Review reports must include:

a. The number of Retrospective Reviews performed for the review period.

b. The following information for each Retrospective Review:
   i. Number of Retrospective Reviews competed
   ii. Number of Retrospective Reviews approved (door validation)
   iii. Number of Retrospective Reviews approved (in general)
   iv. Number of Retrospective Reviews denied (final denial)

v. Number of Retrospective Reviews denied (final technical denial)
vi. Number of Retrospective Reviews denied (absence of PASARR)
vii. Number of Retrospective Reviews voided
viii. Number of Retrospective Reviews de-selected
ix. Number of Retrospective Reviews not open

c. The following information is needed for the approved (door validation) Retrospective Reviews:
i. Provider's name
ii. Provider's NPI
iii. Beneficiary's Medicaid ID
iv. Reviewed door and the validation door
v. Retrospective Review selection date and review period (from date/to date)

d. The following information for denied (final denial, final technical denial, or absence of PASARR) is need for Retrospective Reviews:
i. Provider's name
ii. Provider's NPI
iii. Beneficiary's Medicaid ID
iv. Retrospective Review selection date and review period (from date/to date)

e. The number of Retrospective Reviews denials appealed.

f. The number of Retrospective Review appeals upheld and overturned.

5.0 Ordering

5.1 Authorizing Document
The appropriate authorizing document for the Contract will be a signed Blanket Purchase Order as well as an Agency issued Purchase Order.

6.0 Invoice and Payment

6.1 Invoice Requirements
The agency will use the invoice language defined in Section 20, Terms of Payment in the Standard Contract.

6.2 Payment Methods
The State will make payment for Contract Activities through Electronic Fund Transfer (EFT). As stated in 1984 PA 431, all contracts that the State enters into for the purchase of goods and services must provide that payment will be EFT.

6.3 Procedure
The Contractor must register with the State electronically at http://www.cpexpress.state.mi.us.

7.0 Reserved

8.0 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 (Attachment M) to the individual specified in the Standard Contract Terms (2) of the Contract. The Business Associate performs certain services for the State ("Covered Entity") under the Contract that requires the exchange of information including protected health information under the HIPAA of 1996, as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5). The HIPAA Business Associate Agreement Addendum establishes the responsibilities of both parties regarding HIPAA-covered information and ensures the underlying contract complies with HIPAA.

9.0 Service Level Agreements
A. Inpatient PACER, Selected DME/MS and VDCU Admissions/Continued Stays

Sanctions will be imposed based on the results of the monthly validation conducted by the MDCH Program Manager. The penalty will be determined by the number of incorrect authorizations, authorizations by telephone/electronic computer system not completed in a timely manner, and/or telephone response time with an average time to answer greater than 90 seconds.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The State, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction will be at the sole discretion of the State, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the State will give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract, and the sanction which the State will impose here under. The State, at its sole discretion, may waive the imposition of sanctions.

1. **Number of Incorrect Authorizations**.
   With the beginning of this Contract, and based on the monthly billing validation performed by the MDCH Program Manager, if the Contractor inappropriately authorizes inpatient admissions, transfers, readmissions within 15 days, continued stay for rehabilitative facilities, selected DME/MS and VDCU Admissions and continued stays, the State will give written notice to the Contractor of the number of incorrect authorizations by fax, (hardcopy to follow by certified overnight mail). The Contractor will have 10 calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within 10 calendar days following the notice, the State, without further notice, may impose a sanction of no less than $10,000.00. At the end of each subsequent 10 day period in which the corrective action plan has not been submitted, the State may, without further notice, impose further sanctions in $10,000.00 increments.

   Criterion is set forth below:
   a. Cumulative inappropriate authorizations from the above categories must be at 10% or greater.
   b. $10,000.00 or the amount paid per inappropriate authorization, whichever is less, will be credited to the State by the Contractor.
   c. MDCH reserves the right to increase the number of selected validations to ensure proper authorizations have occurred.

2. **Authorization Process not completed in a timely manner (per Medicaid Policy Manual)**. Upon review by the MDCH Program Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold 25% of the future monthly payments until the Contractor is in compliance and demonstrates adherence to the Contract.

3. **Telephone response time**. If telephone response time is greater than 90 seconds for two consecutive months, the MDCH will withhold 25% of the future monthly payments until the Contractor is in compliance and demonstrates adherence to the Contract.

B. LTC Immediate and Exception Review:
Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH LTC Program Manager. The penalty will be determined by the number of incorrect Immediate and Exception Review determinations; determinations not completed in a timely manner; telephone response time with an average time to answer greater than 90 seconds.

The MDCH Program Manager reserves the right to change the LTC validation process with a 30 day notice to the Contractor. The MDCH Program Manager also reserves the right to change the LTC review process or cancel the Contract with a 30 day notice to the Contractor.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction will be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH will give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1. Number of Incorrect Immediate and Exception Review determinations. With the beginning of this Contract, if the Contractor inappropriately determines LTC admission or enrollment, then the MDCH will give written notice to the

Contractor of the number of incorrect admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor will have 10 calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within 10 calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than $10,000.00. At the end of each subsequent 10 day period in which the corrective action plan has not been submitted, the MDCH may, without further notice, impose further sanctions of $10,000.00.

2. Immediate and Exception Review process not completed in a timely manner The immediate review has to be determined within three business days from the date of receipt of the medical records. Upon review by the MDCH LTC Program Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract. The exception review has 24 hours to respond from the time of the phone call.

3. Telephone response time. If telephone response time is greater than 90 seconds for two consecutive months, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

C. LTC Retrospective Reviews:
For the first year of the Contract, the Contractor is expected to correct any inability to meet Timeframes. The MDCH reserves the right to adjust the number of LTC Retrospective Reviews conducted per provider type with a 30 day notice to the Contractor. The MDCH also reserves the right to change the review process or cancel the Contract with a 30 day notice to the Contractor.

In the second year, monetary sanctions imposed pursuant to this section will be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction will be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH will give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions. Sanctions will be imposed based on the following:

1. Failure to Report. If the Contractor fails to submit, by the due date, any report or other material required by this Contract to be submitted to the MDCH, the MDCH will give written notice to the Contractor of the late report or material by fax (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor will have 10 calendar days following the notice in which to cure the failure by submitting the complete and accurate report or material. If the report or other material has not been submitted within 10 calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than $10,000.00. At the end of each subsequent 10 day period in which the complete and accurate report has not been submitted, the MDCH may, without further notice, impose further sanction of $10,000.00.

2. LTC Retrospective Reviews. The numbers of LTC Retrospective Reviews to be completed are outlined in Section 1.1. Upon review by the MDCH Program Manager, if the LTC Retrospective Reviews from the previous month are not completed correctly or in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract. The Michigan Peer Review Organization has 30 calendar days from the date of receiving the full medical record to make a determination.

EXHIBIT B - RESERVED

EXHIBIT C
PRICING

1. Price proposals must include all costs, including, but not limited to: any one-time or set-up charges, fees, and potential costs that may charge the State.

2. Contractor offers quick payment terms of 1.0% off invoice if paid within 10 days.

3. Prices quoted are firm for the entire length of the Contract.

Proposal Pricing

Payment Schedule - Inpatient PACER, Selected DME/MS, VDCU Admissions and Continued Stays and LTC Immediate and Exception Reviews, Inpatient PACER, Selected DME/MS, VDCU Admissions and Continued Stays and Long Term Care Immediate and Exception Review Appeal Process

The payment schedule will be based on the number of Inpatient PACER, selected DME/MS and VDCU Admissions and continued stay reviews, LTC Immediate and Exception reviews, LTC Immediate and Exception Review Appeal Process with an RN and Inpatient PACER, selected DME/MS and VDCU Admissions/continued stay Appeal Process with RN and Physician (telephonic/electronic) completed the previous month. The Contractor is required to be available at all appeal levels. The Contractor's nurse reviewer/physician reviewer, (if applicable), must be available to testify as to the results of the Inpatient PACER, selected DME/MS, VDCU Admission/continued stay or LTC review at any preliminary or bureau conference; administrative hearing or judicial proceeding.

Payment Schedule - LTC Retrospective Reviews and LTC Retrospective Appeal Process

The payment schedule will be based on the number of LTC Retrospective Reviews completed. The LTC Retrospective Review payment will include the medical/case record review. The Appeal Process for LTC Retrospective Review will be paid separately. Although the Contractor will receive payment upon completion of the LTC Retrospective Review, the Contractor is still required to participate in the Appeal process even though payment has been received.

The Contractor will be paid monthly based on the number of LTC Immediate (NONC), Exception (Telephonic) and LTC Retrospective Reviews completed the previous month of the Contract.

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing	Three Year Pricing
Inpatient PACER	FFS Reviews	1,056.25/month	12,675	$60	$760,500	$2,281,500
	FFS Appeals	RN = 6.25 hours	75 hours	$40 per half hour	$6,000	$18,000
		MD = 6.25 hours	75 hours	$100 per half hour	$15,000	$45,000
LTC	Immediate Reviews	8.33/month	100	$135	$13,500	$40,500
	Exception Reviews	13.33/month	160	$100	$16,000	$48,000
	Immediate & Exc Appeals	RN = 8.33/month	100 hours	$40 per half hour	$8,000	$24,000
		MD = 8.33/month	100 hours	$100 per half hour	$20,000	$60,000

	Retrospective Reviews	150/month	1,800	$47	$84,600	$253,800
	Retrospective Appeals	RN = 41.66 hours/ month	500 hours	$40 per half hour	$40,000	$120,000
		MD = 20.83hours/ month	250 hours	$100 per half hour	$50,000	$150,000
Selected DME/MS and VDCU	Reviews	568.75/month	6,825	$61.75	$421,443.75	$1,264,331.25
	Appeals	RN = 6.25 hours	75	$40 per half hour	$6,000	$18,000
		MD = 6.25 hours	75	$100 per half hour	$15,000	$45,000
				Grand Total	$1,456,043.75	$4,368,131.25

Attachment A

Michigan Department of Community Health (MDCH) Definitions

Admission criteria approved by MDCH: the most current edition of copyrighted criterion used to assess the clinical appropriateness of acute care admission; continued stay and discharge; and quality of care ensuring the proper care setting for the appropriate length of time. The current source document is McKesson® (Interqual).

Beneficiary: all Medicaid eligible individuals in the Fee For Service Program, (FFS), (Title XIX), Children's Special Health Care Services Program (CSHCS dual eligible and CSHCS only) (Title V/XIX), Medicare/Medicaid, (Title XVIII/XIX).

CHAMPS: MDCH's Community Health Automated Medicaid Processing System

CEO: Chief Executive Officer

CPT Codes: Current Procedural Terminology Codes

Durable Medical Equipment/Medical Supplies (DME/MS):
DME: Items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home.
Medical Supplies: Items that are required for medical management of a beneficiary, are disposable, or have a limited life expectancy and can be used in the beneficiary's home.

Emergency Room Criteria: currently accepted standards of care for Emergency Department service consistent with coverage in the Michigan Medicaid Provider Manual Hospital Chapter.

Exception Criteria: specific criteria developed by MDCH to determine whether or not the participant is at risk of imminent institutionalization.

Health Insurance Portability and Accountability Act (HIPAA): a Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services (DHHS) the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative codes sets should be used within those standards; to require the use of national identification systems for health care patients, provider, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

Long Term Care (LTC): for this Contract only, LTC includes those programs that are required to adhere to the Michigan Medicaid Nursing Facility Level of Care Determination definition; specifically Nursing Facilities, MI Choice Waiver Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly (PACE).

MDS: Minimum Data Set-assessment information required for all nursing facility and MI Choice Program in Michigan.

MDS-HC: Minimum Data Set-Home Care assessment information required for all MI Choice Waiver programs in Michigan.

MI Choice Program: MI Choice is Michigan's 1915c(SSA) Home and Community Based Waiver for Elderly and Disabled. Services are provided to participants within the community to maintain the most integrated setting possible.

Michigan Department of Community Health (MDCH): the State of Michigan Department requesting the services.

Michigan Medicaid Nursing Facility Level of Care Determination: Medicaid criteria established by the MDCH, utilized by Medicaid providers, to determine a beneficiary's medical/functional eligibility for nursing facility admission or MI Choice Waiver and PACE program enrollment.

National Provider Identifier (NPI) Number: NPI is part of the HIPAA mandate requiring a standard unique identifier for health care providers.

Nurse Reviewer: A registered professional nurse with a current Michigan license and with appropriate education and clinical background, trained in the performance of Inpatient PACER, Selected DME/MS, VDCU Admissions and Continued Stays and Nursing Facility Level of Care Review and Certification utilization review and quality assurance to determine adherence to Medicaid policies.

Nursing Facility: A nursing home, county medical care facility, or hospital long-term care unit, with Medicaid certification.

Nursing Facility Level of Care Exception Process Criteria: Criteria established by the MDCH, utilized by the Contractor, in determining Medicaid eligibility based on frailty for beneficiaries who do not meet the online Michigan Medicaid Nursing Facility Level of Care Determination criteria.

Nursing Facility Level of Care: Each state that participates in the Medicaid program is required to provide nursing facility care as a mandatory state plan service. Each state must determine function/medical eligibility criteria to determine the appropriateness for that setting. Federal regulations state that Medicaid covered nursing facility care must include the following:
(A) skilled nursing care and related services for residents who require medical or nursing care,
(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

PACE: The Program of All Inclusive Care for the Elderly, a capitated community program for persons with LTC needs. Funds are blended from both Medicare and Medicaid sources.

PACER: Prior Authorization Certification Evaluation Review. The Prior Authorization Certification Evaluation Review number consists of ten digits and is generated and assigned by the CHAMPS system.

PASARR: The Pre-Admission Screening/Annual Resident Review is required to be completed for all potential nursing facility residents. This review ensures that persons with mental health conditions are placed in the most appropriate setting.

Peer Review Organization (PRO): an organization that is Utilization Review Accreditation Commission (URAC) approved and experienced in utilization review and quality assurance which meets the guidelines set forth in 42 USC 1320(c) (1) and 42 CFR 475. Note: QIO-like entities satisfies the requirements of the Contract and are qualified to bid on the proposal.

Physician Reviewer: a physician licensed to practice medicine in Michigan engaged in the active practice of medicine; board certified or board eligible in his/her specialty; with admitting privileges in one or more Michigan hospitals; familiar with Medicare principles; and experienced in Nursing Facility Care and Utilization Review.

Proposal: the response to this RFP submitted to the Department by a bidder.

Provider: Medicaid enrolled Provider for Inpatient Hospital, Selected Durable Medical Equipment/Medical Supplies, Ventilator Dependent Care Units (within a Hospital or Nursing Facility) and Long Term Care Facilities.

Readmission: Any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital.

SI/IS: Severity of Illness/Intensity of Service.

Utilization Review Accreditation Commission (URAC): a non-profit charitable organization founded in 1990 to establish standards for the health care industry.

Ventilator Dependent Care Unit (VDCU): A LTC facility (unit within a Hospital or Nursing Facility) contracted with Medicaid to provide care for beneficiaries that are ventilator dependent and for which there is an enhanced rate.

Attachment B

REQUEST for HEARING

INSTRUCTIONS

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper. This form is also available on-line at: www.michigan.gov/mdch Click on *Inside Community Health* Click on *Operations Administration*. Click on *Michigan Administrative Hearing System for the Department of Community Health*

A hearing is an impartial review of a decision made by the MDCH or one of its contract agencies that a client believes was made in error.

GENERAL INSTRUCTIONS:

- Read ALL instructions before completing the attached form.
- Complete **Section 1** using the name of the client (even if the client has a guardian or is a minor).
  - Complete **Section 2** only if you want someone to represent you at the hearing.
  - **Do NOT** complete Section 4. Make a copy for your records.
  - If you have any questions, please call toll free: **1 (877) 833-0870**.
  - After you complete this form, mail or fax to:

MICHIGAN ADMINISTRATIVE HEARING
SYSTEM FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763 LANSING MI 48909 Fax (517) 373-4147

- You may choose to have another person represent you at a hearing.
  → The person can be anyone you choose but he/she must be at least 18 years of age.
  → You MUST give this person written permission to represent you.
  → You may give written permission by checking **YES** in **SECTION 2 and having the person who is representing you complete and sign SECTION 3**. **You MUST still complete and sign SECTION 1.**
  → Your guardian or parent of minor may represent you. A copy of the court order naming the guardian must be included with this request.

- The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

- If you need help with reading, writing, or hearing, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health at (877) 833-0870. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية ميتشيجن.	**1 (877) 833-0870**

Completion:	Is Voluntary

DCH-0092 (MAHS) INSTRUCTION SHEET (Rev. 2/13)

See the Request Form on Reverse

Attachment B (cont.)

REQUEST FOR HEARING

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING, MI 48909
1 (877) 833-0870 – Fax (517) 373-4147

SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Client Name			Telephone Number ( )	Client's Social Security Number
Client's Address (No. & Street, Apt. No.)			Signature of client/guardian/parent of minor	Date Signed
City	State	ZIP Code		
What **Agency** took the action or made the decision that you are appealing?				Case Number

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing?

☐ **NO**

☐ **YES** (Please Explain Here):

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing?

☐ **NO** ☐ **YES** (If YES, have the individual complete and sign section 3)

SECTION 3 – Authorized Hearing Representative Information:

Name of Representative			Representative Telephone Number ( )	
Address (No. & Street, Apt. No.)			Representative Signature	Date Signed
City	State	ZIP Code		

SECTION 4 – To be completed by the AGENCY distributing this form to the client

Name of Agency			AGENCY Contact Person Name
AGENCY Address (No. & Street, Apt. No.)			AGENCY Telephone Number ( )
City	State	ZIP Code	State Program or Service being provided to this appellant

This form is also available on-line at:

www.michigan.gov/mdch
Click on *Inside Community Health*
Click on *Operations Administration*
Click on *Michigan Administrative Hearing System for the Department of Community Health*
DCH-0092 (MAHS) (Rev 2/13)
Attachment C

Long Term Care
Adequate Action Notice

Date
Name
Address

Dear {bene name}:

Following a review of your long term care needs, it has been determined that you do not qualify for nursing facility level of care services based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). Because you do not qualify under the LOCD, **Medicaid will not pay for your services**. You are legally responsible for services received by your provider. **Your provider may not bill Medicaid for services they provide to you**.

The services you did not qualify for in the LOCD are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d)

If you do not agree with this action, you may request a **Medicaid Fair Hearing**: To request a Medicaid Fair Hearing, complete a "Request for Fair Hearing" form and return it in the enclosed pre-addressed envelope, or mail it to:

Michigan Administrative Hearing System (MAHS)
Michigan Licensing and Regulatory Affairs
P.O. Box 30763
Lansing, MI 48909

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,

[Provider Representative]

Enclosures:
Hearing Request Form
Return Envelope

cc: Elizabeth Aastad, MDCH

Attachment D

Long Term Care
Advance Action Notice – NO LONGER LOCD ELIGIBLE

Date
Name
Address

Beneficiary Salutation:

Following a review of your long term care needs, it has been determined that you no longer qualify for nursing facility level services based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) and services will be terminated within 90 days from the date of this notice. The services you did not qualify for in the LOCD are: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d)

If you do not agree with this action, you may request a **Medicaid Fair Hearing**: You will continue to receive the affected services UNTIL the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action. If you continue to receive benefits because you requested a Medicaid Fair Hearing **you may be required to repay the benefits you received during pendency of the Medicaid Fair Hearing**. This may occur if:

- **The proposed termination or denial of benefits is upheld in the hearing decision (decision is in favor of MDCH)**
- You withdraw your hearing request
- Your or the person you asked to represent you does not attend the hearing

To request a Medicaid Fair Hearing, complete a "Request for Fair Hearing" form and return it in the enclosed pre-addressed envelope, or mail it to:

Michigan Administrative Hearing System (MAHS)
Michigan Licensing and Regulatory Affairs
P.O. Box 30763
Lansing, MI 48909

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,

[Provider Representative]

Enclosures:
Hearing Request Form
Return Envelope

cc: Elizabeth Aastad, MDCH

Attachment E

NURSING FACILITY RETROSPECTIVE REVIEW NOTIFICATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

Dear Administrator:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the nursing facility resident's(s') medical records that must be submitted by the provider, and received by (Contractor), within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the **Signed Computer-Generated** Freedom of Choice Form or **Signed Hard Copy** Freedom of Choice form **attached to the Computer-Generated** Freedom of Choice form
3. PASARR evaluation-level 1, and level 2 when indicated (Form-DCH-3877 and 3878)
4. All Minimum Data Set documents for the period under review
5. Face sheet
6. Original History and Physical
7. Physician Orders for the period under review
8. All nursing notes, rehabilitation notes, physician progress notes, or interdisciplinary team notes for the period under review
9. Skilled therapy evaluations and progress notes for the period under review
10. Discharge plans
11. Medicare Recertification/Certification form

Again, copies of the above mentioned resident's (s') medical records for this review must be submitted to, and received by, (Contractor) within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is_____.

Failure to provide (Contractor) with the requested medical records will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review
Contractor Name
Address

If you have any questions, please contact (*Contract Representative*) at (---).

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

Attachment F

MI CHOICE WAIVER RETROSPECTIVE REVIEW NOTIFICATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

Dear Program Director:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the MI Choice Waiver participant's(s') medical records that must be submitted by the provider, and received by (Contractor), within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided to the participant(s) during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the **Signed Computer-Generated** Freedom of Choice Form or copy of the **Signed** Hard Copy Freedom of Choice form **attached to the Computer-Generated** Freedom of Choice form.
3. Minimum Data Set –Home Care Assessment documents for the period under review
4. All available medical records for the period under review
5. All physician notes and orders for the period under review
6. All MI Choice Program contact notes from the family, friends or the participant for the period under review
7. MI Choice Program's Plan of Care for the participant during the period of review

Again, copies of the above medical records for the participant's (s') review must be submitted to, and received by, (Contractor) within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is (**Date)**.

Failure to provide (Contractor) with the requested medical record will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review
Contractor
Address

If you have any questions, please contact (name) at (phone number).

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

Attachment G

PACE RETROSPECTIVE REVIEW NOTIFICATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

Dear Administrator:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the PACE participant's medical records that must be submitted by the organization, and received by (Contractor), within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided to the participant(s) during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the **Signed Computer-Generated** Freedom of Choice Form or copy of the **Signed** Hard Copy Freedom of Choice form **attached to the Computer-Generated** Freedom of Choice form.
3. Minimum Data Set Assessment documents for the period under review
4. All available medical records for the period under review
5. All physician notes and orders for the period under review
6. All PACE Program contact notes from the family, friends or the participant for the period under review
   PACE Program's Plan of Care for the participant during the period of review

Again, copies of the above medical records for the participant's (s') review must be submitted to, and received by, (Contractor) within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is (**Date)**.

Failure to provide (Contractor) with the requested medical record will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review
Contractor
Address

If you have any questions, please contact (name) at (phone number).

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

Attachment H

INCOMPLETE RETROSPECTIVE REVIEW - MEDICAL RECORD SUBMISSION REMINDER (PENDING A TECHNICAL DENIAL)

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

RE: (Beneficiary's Name)

Dear Nursing Facility Administrator/MI Choice Program Director/PACE Director:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

On (DATE) the following medical records were requested from your facility for the review period from (DATE) to (DATE) Beneficiary Medicaid ID: (Medicaid ID)

The medical records listed below, as requested in the previous notice, must be received by the Contractor within **fourteen (14) calendar** days from the date of this letter. Should the requested documentation not be received by (date), a notice of Retrospective Review Final Technical Denial will be forwarded to MDCH for further action by the Department.

1. (List Item)
2. (List Item)
3. (List Item)

If you have any questions, please contact (name) at (phone number).

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

Attachment I

FINAL TECHNICAL DENIAL

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

RE**:** Notice of Final Denial

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

On (date) Contractor sent an INCOMPLETE RETROSPECTIVE REVIEW-MEDICAL RECORD SUBMISSION REMINDER letter to your (facility/agency) based upon non-compliance to the request of medical records to conduct Retrospective Reviews on behalf of MDCH, in compliance with state policy. Medical records as requested in the INCOMPLETE RETROSPECTIVE REVIEW-MEDICAL RECORD SUBMISSION REMINDER letter were not forwarded to (Contractor) as requested in that notice.

This notice of RETROSPECTIVE REVIEW FINAL TECHNICAL DENIAL will be forwarded to MDCH as notice of inaction by you (facility/agency) to the requests made by (Contractor). The (Contractor) will close this file as of the date of this notice. Further action regarding this issue will be taken by MDCH.

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

Attachment J

NURSING FACILITY RETROSPECTIVE REVIEW DETERMINATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

RE: (beneficiary's name)

Dear Administrator,

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

The Contractor nurse reviewer has conducted a Retrospective Review by evaluating the medical record documentation submitted by your facility for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by (Contractor), it has been determined that:

Findings from this retrospective review have been forwarded to MDCH for further evaluation and may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

Attachment K

MI CHOICE WAIVER RETROSPECTIVE REVIEW DETERMINATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

RE: (beneficiary's name)

Dear Administrator/Director of Nursing:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

The Contractor nurse reviewer has conducted a Retrospective Review by evaluating the case record documentation submitted by your agency for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by (Contractor), it has been determined that:

Findings from this retrospective review have been forwarded to MDCH for further evaluation and may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

Attachment L

PACE RETROSPECTIVE REVIEW DETERMINATION

DATE:
NAME:
ADDRESS:
CITY, STATE, ZIP

RE: (beneficiary's name)

Dear Administrator:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

The Contractor nurse reviewer has conducted a Retrospective Review by evaluating the medical record documentation submitted by your organization for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by (Contractor), it has been determined that:

Findings from this retrospective review have been forwarded to MDCH for further evaluation and may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

Attachment M

HIPAA BUSINESS ASSOCIATE AGREEMENT ADDENDUM

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

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

RECITALS

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

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

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

1. Definitions.

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

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

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

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

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

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

2. Obligations of Business Associate.

The Business Associate agrees to

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

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

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

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

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

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

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

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

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

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

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

l. within ten days after a written request by the Covered Entity, the Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Addendum for the purpose of determining whether the Business Associate has complied with this Addendum; provided, however, that: (i) the Business Associate and the Covered Entity must mutually agree in advance upon the scope, timing and

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location of such an inspection; (ii) the Covered Entity must protect the confidentiality of all confidential and proprietary information of the Business Associate to which the Covered Entity has access during the course of such inspection; and (iii) the Covered Entity or the Business Associate must execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, the Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve the Business Associate of its responsibility to comply with this Addendum. The Covered Entity's (i) failure to detect or (ii) detection, but failure to notify the Business Associate or require the Business Associate's remediation of any unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Addendum.

3. Permitted Uses and Disclosures by the Business Associate.

a. Business Associate may use or disclose PHI:

(i) for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; provided, however, either (A) the disclosures are required by law, or (B) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;
(ii) as required by law;
(iii) for Data Aggregation services relating to the health care operations of the Covered Entity;
(iv) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and
(v) for any other purpose listed here: carrying out the Business Associate's duties under the Contract.

b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.
c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations

Covered entity agrees to

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

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

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

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

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

6. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by the Business Associate of any provision of this Addendum, as determined by the Covered Entity, constitutes a material breach of the Addendum and is grounds for termination of the Contract by the Covered Entity under the

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provisions of the Contract covering termination for cause. If the Contract contains no express provisions regarding termination for cause, the following apply to termination for breach of this Addendum, subject to 6.b.:

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

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

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

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

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

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

(i) retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(ii) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;

(iii) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Business Associate retains the PHI;

(iv) not use or disclose the PHI retained by the Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and

(v) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by the Business Associate when it is no longer needed by the Business Associate for its proper management and administration or to carry out its legal responsibilities.

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

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

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

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

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the extent to which the Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this Addendum.

11. Amendment.

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

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

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

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

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

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

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

18. Representatives and Notice.

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

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

Covered Entity Representative:

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

Business Associate Representative:

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

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

Business Associate	**Covered Entity**
[INSERT NAME]	[INSERT NAME]
By:_____	By:_____
Date:_____	Date: _____
Print Name: _____	Print Name:_____
Title:_____	Title:_____

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH

ADMINISTRATIVE HEARING PAMPHLET

This replaces the March 5, 2005, version in its entirety.

This document is neither intended nor shall it be construed as the State Office of Administrative Hearings and Rules (SOAHR) or the Department of Community Health's (DCH) regulation, statement, standard, policy, ruling, or instruction of general applicability that implements or applies law enforced or administered by State Office of Administrative Hearings and Rules or the Department of Community Health, or that prescribes the organization, procedure, or practice of the State Office of Administrative Hearings and Rules or the Department of Community Health, including the amendment, suspension, or rescission of the law enforced or administered by the State Office of Administrative Hearings and Rules or the Department of Community Health.

QUESTIONS

Questions should be directed to the State Office of Administrative Hearings and Rules for the Department of Community Health, P.O. Box 30763, Lansing, Michigan 48909, or by telephone at 1-877-833-0870.

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100 How to Contact SOAHR/DCH

Address: PO Box 30763
Lansing, MI 48909

Telephone: (877) 833-0870
(517) 334-9500

Facsimile: (517) 334-9505

E-Mail: administrativetribunal@michigan.gov

110 Statement and Purpose

The State Office of Administrative Hearings and Rules (SOAHR) for the Department of Community Health (DCH) hears a wide variety of appeals of administrative decisions from DCH and DCH contract agencies. The Administrative Law Judges (ALJ) of the State Office of Administrative Hearings and Rules for the Department of Community Health are delegated by the Director of the DCH to hold hearings in accordance with the Administrative Procedures Act, the Social Welfare Act, the Public Health Code, Mental Health Code, the Administrative Code, Social Security Act and its regulations and/or other federal codes.

The information contained in this transmittal is intended to provide information regarding the hearings process and to provide as much uniformity of practice and procedures as current laws and regulations permit. It is to be used to provide information regarding the relevant laws and regulations, not in place of them.

120 Legal Authority

MCL 24.287, 330.1236, 330.1238, 330.1407, 330.1536, 333.20161, 333.20168, 333.20958, 333.21774, 333.21799a, 400.1 et seq., 400.9; 7 CFR 246.1 et seq.; 42 CFR 431.200 et seq., 42 CFR 438 et seq. 42 CFR 488.335, and Michigan Administrative Code Rule 330.2052 and Rule 400.919.

130 Definitions

Action:

- Termination, suspension, reduction or denial of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Social Security Act;

- **For Medicaid Recipients of Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP):** A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

  - Denial or limited authorization of a requested service, including the type or level of service.
  - Reduction, suspension, or termination of a previously authorized service.
  - Denial, in whole or in part, of payment for a service.
  - Failure to make a standard authorization decision and provide notice about the decision with **14 calendar days** from the date of receipt of a standard request for service.
  - Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
  - Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP/MCO.
  - Failure of the PIHP/MCO to act within **45 calendar days** from the date of a request for standard appeal.
  - Failure of the PIHP/MCO to act within **three (3) working days** from the date of a request for an expedited appeal.
  - Failure of the PIHP/MCO to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as "**B3**" waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Administrative Hearing: An impartial review of a decision made by the Department of Community Health (DCH) or one of its contract agencies presided over by a SOAHR/DCH Administrative Law Judge.

Administrative Law Judge (ALJ): A person designated by SOAHR/DCH to conduct hearings in an impartial and unbiased manner.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Adverse Action: Includes but is not limited to:

Women, Infants, and Children Program (WIC):

(i) Denial of the vendor's application for authorization based on the vendor selection criteria for competitive price or for minimum variety and quantity of authorized supplement foods or on a determination that the vendor is attempting to circumvent a sanction.
(ii) Termination of an agreement for cause.
(iii) Disqualification from the WIC program.
(iv) Imposition of a fine or civil money penalty in lieu of disqualification.

Medicaid Provider:

(i) A suspension or termination of provider participation in the medical assistance program.
(ii) A denial of an applicant's request for participation in the medical assistance program.
(iii) A denial, revocation, or suspension of a license or certification issued by the Department to allow a facility to operate.
(iv) The reduction, suspension, or adjustment of provider payments.
(v) Retroactive adjustments following the audit or review and determination of the daily reimbursement rates for institutional providers.

Adult Benefit Waiver:
A discontinuation, termination, suspension or reduction of adult benefit services.

Adverse Determination: A determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7) of the Social Security Act that the individual does not require the level of services provided by the nursing facility or that the individual does or does not require specialized services.

Appeal: Request for a review of an "action."

Appellant: A beneficiary, resident, patient, consumer or responsible party requesting a hearing.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Authorized Hearing Representative (AHR): - A person, legally designated, to stand in for, or represent the Appellant in the hearing process.

Beneficiary: An individual who has been determined eligible for Medicaid.

Contested Case: A proceeding under the Michigan Administrative Procedures Act in which a determination of the legal rights, duties, or privileges of a named party is required by law to be made by an agency after an opportunity for an evidentiary hearing.

Date of Action: The date on which a termination, suspension, reduction, transfer or discharge become effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review (PASARR) requirements of section 1919(e)(7) of the Act.

DCH Contract Agency: Any agency or organization that has contracted with the Department that either determines eligibility for a Department program, or delivers a service provided under a Department program to a beneficiary, patient, or resident.

Department Contact: The individual in a substantive area identified as responsible for the decision for which the hearing is being held.

Department Representative: A DCH or DCH Contracted Agency staff person assigned to serve as the liaison between the agency or DCH organization and the State Office of Administrative Hearings and Rules for the Department of Community Health.

Expedited Hearing: A hearing that is held within three (3) workdays after receipt of hearing request because a delay in conducting the hearing would seriously jeopardize the life or health of the Medicaid beneficiary or would jeopardize his/her ability to attain, maintain or regain maximum function.

Expedited Local Appeal: The expeditious review of an action, requested by a managed care beneficiary or the beneficiary's provider when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP/MCO determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP/MCO must grant the request.

Fair Hearing: An impartial review of a decision made by the Department of Community Health (DCH) or one of its contract agencies presided over by a SOAHR/DCH Administrative Law Judge.

Final Determination Notice: A notice of an adverse action for Medicaid enrolled providers which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule, or guideline under which the action is taken; and the right to a hearing.

Grievance: Medicaid beneficiary's expression of dissatisfaction about PIHP/MCO service issues, **other than an action**. Possible subjects for grievances included, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of Medicaid beneficiary's grievance (expression of dissatisfaction) about PIHP/CHMSP/MCO service issues **other than an action**.

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

HIPAA: Health Insurance Portability and Accountability Act.

Local Appeal Process: Impartial local level PIHP/MCO review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Managed Care Organization (MCO): An entity that has, or is seeking to qualify for a comprehensive risk contract under this part, and that is:

(1) A Federally qualified HMO that meets the advance directive requirements of subpart I of part 489 *of* this chapter; or

(2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

(ii) Meets the solvency standards of §438.116.

42 CFR 438.2

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Supports waiver, Children's Waiver, MIChoice Waiver and/or Section 1915(b)(3) of the Social Security Act.

Mental Health Financial: the ability of a responsible party to pay for the cost of mental health services.

Mental Health Transfer: a resident in a state facility may be transferred to any other center, or to a hospital operated by the Department, if the transfer would not be detrimental to the resident and the responsible community mental health services program approves the transfer.

Notice of Disposition: Written statement of the PIHP/MCO decision for each local appeal and/or grievance provided to the beneficiary.

Program of all-inclusive care for the elderly (PACE): Provides pre-paid, capitated comprehensive health care services to frail, older adults.

Prepaid Inpatient Health Plan (PIHP) – An entity that:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use the State plan payment rates;
2. Provides, arranged for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

200 Grievance System General Requirements for Medicaid Managed Care Beneficiaries

Federal regulations (42 CFR 438.200 *et seq.*) requires the state to ensure through its contracts with PIHP/MCOs, that each PIHP/MCO has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP/MCO appeal process for challenging an "action" taken by the PIHP/MCO or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP/MCO grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "action".
- The right to **concurrently** file a PIHP/MCO level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP/MCO level grievance regarding other services complaints.
- The right to request a State fair hearing **before exhausting** the PIHP/MCO level appeal of an "action".
- The right to request, and have, Medicaid benefit continued while a local PIHP/MCO appeal and/or State fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP/MCO. The provider may file a grievance or request for a State fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so.

210 Service Authorization Decisions for Medicaid Managed Care Beneficiaries or Applicants

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP/MCO **must provide** the beneficiary a written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service, with a possible extension of **14 additional calendar days** if the beneficiary or provider requests an extension **OR** if the PIHP/MCO justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest.

- **Expedited Authorization:** In cases in which a provider indicates, or the PIHP/MCO determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP/MCO must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

  If the beneficiary requests an extension, or if the PIHP/MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP/MCO may extend the three working day time period by up to **14 calendar days**.

When a **standard or expedited** authorization of services decision is extended, the PIHP/MCO must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP/MCO must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

300 Notices of Action

A. Medicaid beneficiaries (including PACE Enrollees)

There are two (2) types of Notice of Action:
Adequate notice and **Advance notice**

Adequate notices are sent on the effective date of the action. An adequate notice is used for a denial of requested service or a denial of a new authorization.

Advance notice must be mailed at least 12 days before the proposed effective date. An advance notice is used for termination, suspension, or reduction of a Medicaid service. A DCH-0092, Hearing Request Form (Exhibit I) or its equivalent shall be sent to the appellant with all adequate and advance notices.

The client must be sent a written notice at the time of **each "action"**.

1. An adequate notice must contain:

   - A statement of what action is being taken by the DCH or any contract agency or nursing facility;
   - The reasons for the intended action;
   - The specific regulations that support the action;
   - Explanation of the individual's right to request a fair hearing and instructions for doing so;
   - An explanation that the beneficiary may represent himself/herself or use legal counsel, a relative , a friend or other spokesperson.

2. An advance notice must also contain:

   - The circumstances under which services will be continued pending resolution of the appeal;
   - How to request that benefit be continued; and
   - The circumstances under which the beneficiary may be required to pay the costs of these services.

3. Limited exceptions to the advance notice requirement.

The DCH/DCH contract agent may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The DCH/DCH contract agent has factual information confirming the death of the beneficiary.
- The DCH/DCH contract agent receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.

- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns DCH/DCH contract agent mail directed to him/her indicating no forwarding address.
- The DCH/DCH contract agent establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician.
- The date of the action will occur in less than **12 calendar days**.

4. Medicaid services are to be continued during the pendency of the State fair hearing **if:**

   - The beneficiary specifically requests to have the services continued, and
   - The beneficiary files the appeal within 12 days of the date on the notice, and
   - The appeal involves the termination, suspension or reduction of a previously authorized service, and
   - The original period covered by the original authorization has not expired.

5. Medicaid services are continued or reinstated while an appeal is pending, the services must be continued until one of the following occurs:

   - The beneficiary withdraws the appeal.
   - An Administrative Law Judge orders a decision which is adverse to the beneficiary.
   - The time period or service limits of the previously authorized service has been met.

Exception: Do not provide a notice when you are implementing a hearing decision or a policy hearing authority decision. The hearing decision serves as notice of the action.

B. Medicaid Managed Care Beneficiaries Notice State Fair Hearings

Medicaid beneficiaries served by PIHP/MCOs have additional rights provided by federal regulations at 42 CFR 438 et seq.

The content of both adequate and advance notices must include an explanation of:

- What action the PIHP/MCO has taken or intends to take.
- The reason(s) for the action.
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- The beneficiary's or provider's right to file a PIHP/MCO appeal, and instructions for doing so.
- The beneficiary's right to request a State fair hearing, and instructions for doing so.
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself/herself or use legal counsel, a relative, a friend or other spokesperson.

The content of an advance notice must <u>also</u> include an explanation of:

- The circumstances under which services will be continued pending resolution of the appeal,
- How to request that benefit be continued, and
- The circumstances under which the beneficiary may be required to repay the costs of these services.

And:

- The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP/MCO to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.

Service Authorization decisions will:

Constitute an **"action"** if the service authorized is less in amount, duration or scope than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP/MCO **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP/MCO has taken, or intends to take and the process available to appeal the decision.

Notices must be mailed:

- **At least 12 calendar days before** the date of an action to terminate, suspend or reduce previously authorized Medicaid covered service(s) (Advance).
- **At the time of the decision** to deny payment for a service to deny a newly requested service (Adequate).
- **Within 14 calendar days** of the request for standard service authorization decision to deny or limit services (Adequate).
- **Within three (3) working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

C. Pre-Admission Screening and Annual Resident Review (PASARR, also known as OBRA)

Notices of actions or adverse determinations for PASARR recipients **also** must comply with the following notice requirements:

- Is a nursing facility level of services needed?
- Are specialized services needed?

- The placement options that are available to the individual consistent with these determinations; and
- The rights of the individual to appeal the determination.

D. Adult Benefit Waiver

There are two types of written notices – **timely and adequate.**

- **Timely Notice**
  A timely notice is mailed with the proposed change at least ten days before the action would become effective.

- **Adequate Notice**
  An adequate notice is mailed with the proposed change no later than the date upon which the action would become effective.

  See Section A (Medicaid Beneficiaries) for Notice Requirements.

E. Women, Infants, and Children (WIC) Participant

At the time of a claim against an individual for improperly issued benefits or at the time of participation denial or of disqualification from the Program, the local agency shall inform each individual in writing of the right to a local level hearing, of the method by which a local level hearing may be requested, and that any positions or arguments on behalf of the individual may be presented personally or by a representative such as a relative, friend, legal counsel or other spokesperson. Such notification is not required at the expiration of a certification period.

A local level hearing will be held. The local level hearing decision must include a notice of the Appellant's right to request a hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health, the time limit for requesting a hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health and the address and phone number of the State Office of Administrative Hearings and Rules for the Department of Community Health.

F. Women, Infants, and Children (WIC) Vendor

1. The Department shall provide to the vendor written notification of the adverse action that includes: (1) the procedures to follow to obtain an administrative hearing; (2) the reasons for the adverse action; (3) the effective date of the adverse action, if applicable.

2. Notification of the adverse action shall be mailed to a vendor at least 21 calendar days in advance of the effective date of action except as provided in Section 200 below for 15-day Termination Orders.

3. The effective date of the termination and permanent disqualification of a vendor as the result of a conviction of the vendor for trafficking in food instruments or selling firearms, ammunition, explosives, or controlled substances (as defined in Section 102 of the Controlled Substance Act – 21 USC 802) in exchange for food instruments shall be on the date of receipt of the notice of adverse action by the vendor. A vendor shall not be entitled to receive any compensation for revenues lost as a result of such termination and disqualification.

4. Except as provided in paragraph C above and in Section 7 below, a vendor who has timely appealed an adverse action by the Department may be allowed to remain on the WIC Program until the effective date of the final order or the contract expires, whichever occurs first. An appeal shall not require that the Department enter into a new contract with the vendor after expiration of the current contract.

400 Hearing Requests and Deadlines for Hearing Requests

A. All Programs

All requests for a hearing must be in writing. The hearing request should provide the name, address and telephone number of the person for whom the hearing is being requested. The name, address, and telephone number of the person requesting the hearing, if different, should be included. The benefit or program involved should be clearly identified. The hearing request should identify what decision is being challenged.

The State Office of Administrative Hearings and Rules for the Department of Community Health will deny hearing requests signed by unauthorized persons and requests without original signatures.

B. Medicaid Beneficiaries and Adults Benefit Waiver Beneficiaries

The beneficiary or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The written hearing request must be received within the 90-day period by the State of Michigan.

C. Lead Abatement

The request for a hearing must be made in writing, no later than 15 working days after receipt of a citation or notice of revocation or suspension of accreditation or certification.

D. Medicaid Managed Care Beneficiaries Local Level Appeal

Medicaid beneficiaries participating in managed care are **NOT** required to exhaust MCO and PIHP level appeals before they request a hearing. Medicaid managed care beneficiaries may process simultaneous appeals.

E. Mental Health Transfers

An appeal of a non-emergency transfer may be made at any time before the transfer. An appeal of an emergency transfer may be made up to seven (7) days after the transfer.

F. Mental Health Financial

The individual or Authorized Hearing Representative may appeal a determination of financial liability made by the Department within 30 days of the date the determination was given or mailed to the individual, spouse, or parent.

G. Medicaid Provider

This section applies only to Medicaid <u>enrolled</u> providers

Any provider participating, or applicant wishing to participate in the Medicaid Program may appeal an adverse action taken by the DCH.

Medicaid provider hearings are governed by Social Welfare Act (MCL 400.1 et seq.) and 1979 AC, R 400.3401 through 400.3425

H. Certificate of Need (CON)

Certificate of Need hearings are governed by the Public Health Code and 1986 AACS, R 325.9101 et seq.

A request for a hearing shall be filed within 15 days of the applicant's receipt of the Department's proposed decision or receipt of notice of reversal by the director of a proposed decision that is an approval.

I. Women, Infants, and Children (WIC) Vendor

Request for Hearing

1. An appeal is initiated by filing a request for an administrative hearing with the Department. The request shall be addressed to:

   State Office of Administrative Hearings and Rules
   for the Department of Community Health
   P.O. Box 30763
   Lansing, MI 48909

2. A request for an administrative hearing shall be made in writing and shall include a statement of the facts asserted, the relief sought, and if the vendor is represented by legal counsel, the name, address and telephone number of the attorney.

3. The Department must receive a request for an administrative hearing within 21 calendar days of the date of mailing of the adverse action notice to the Appellant. Any request for an administrative hearing received later than 21 days after the date of mailing of the adverse action notice is untimely and an administrative hearing will not be conducted.

15-Day Termination Orders

1. Upon a finding that the vendor has violated its contract, the regulatory or statutory provisions governing the WIC Program or the State Plan of Program Operation and Administration approved by the United States Department of Agriculture which seriously affect the public health, safety or welfare or the integrity of the WIC Program, the Department may issue an order terminating a vendor's WIC contract effective 15 days from the date of service of the order. The order shall incorporate the Department's findings.

2. Upon issuance of a 15-Day Termination Order, the Department shall provide the vendor with an opportunity for a hearing within five business days after the service of the Order. "Business day" means a day of the year, exclusive of a Saturday, Sunday or a State holiday. The hearing date, time and location shall be specified in the 15-Day Termination Order. Except as modified by this section, the hearing shall be conducted in accordance with these Administrative Hearing Procedures for Vendors.

3. The conduct of a hearing under this section shall not suspend the effectiveness of the Department's 15-Day Termination Order.

4. A 15-Day Termination Order may include sanctions in addition to contract termination, such as disqualification of the vendor from the WIC Program.

J. Women, Infants, and Children (WIC) Participant

The Appellant may appeal a local-level WIC hearing decision to the State Office of Administrative Hearings and Rules for the Department of Community Health, provided that the request for appeal is made within 15 days of the mailing date of the local-level hearing decision notice.

410 Filing the Request for Hearing

All Programs

All hearing requests should be mailed to:

State Office of Administrative Hearings and Rules
for the Department of Community Health
P.O. Box 30763
Lansing, MI 48909

If a hearing request is received in another location, a copy of the request should immediately be faxed to the State Office of Administrative Hearings and Rules for the Department of Community Health at (517) 334-9505. The original request should be forwarded to the State Office of Administrative Hearings and Rules for the Department of Community Health within seven (7) days.

420 Request for Expedited Hearings

Expedited hearings may be granted by the State Office of Administrative Hearings and Rules for the Department of Community Health. The client, authorized representative or Department may call the State Office of Administrative Hearings and Rules for the Department of Community Health at its toll-free number to request an expedited hearing.

430 Processing Hearing Requests

Medicaid Beneficiaries; Mental Health Financial; WIC Participant; Adult Benefit Waiver Beneficiaries

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the Department Representative. The purpose of this fax copy of the hearing request is to alert the Department Representative that a request for hearing has been filed and to allow the Department Representative to begin to prepare for a hearing and/or settle the case.

Lead Abatement

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the Lead Hazard Remediation Program. The Program shall file with the State Office of Administrative Hearings and Rules for the Department of Community Health a copy of its notice and/or citation and supporting documentation within 14 days.

Medicaid Provider

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the designated Department Representative. The Appeals Section shall file with the State Office of Administrative Hearings and Rules for the Department of Community Health, within 30 days after receipt by the Department of the hearing request, a copy of the final determination notice and supporting documentation.

Mental Health Transfer

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to the facility transfer coordinator. The transfer coordinator is responsible for faxing the transfer order and written Community Mental Health approval to the State Office of Administrative Hearings and Rules for the Department of Community Health no later than the day before the hearing.

Certificate of Need

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules for the Department of Community Health will assign a docket number and fax a copy of the hearing request to Certificate of Need (CON) Program office. The CON office must file with the State Office of Administrative Hearings and Rules for the Department of Community Health a copy of its notice to the Applicant and supporting documentation within 14 days.

Women, Infants, and Children (WIC) Vendor

A. Following timely receipt of a written request for an administrative hearing, the Department shall provide the vendor with an opportunity for a hearing at the offices of the Michigan Department of Community Health.

B. Notification of the hearing shall be sent certified mail and shall include: the time and location of the hearing.

C. The notice of hearing must be mailed at least ten (10) calendar days prior to the scheduled administrative hearing date.

Involuntary Transfer of Discharge from a Nursing Facility

Upon receipt of a request for hearing the State Office of Administrative Hearings and Rules for the Department of Community Health will schedule an informal hearing no sooner than seven (7) days after the request for hearing is received, but no later than 14 days.

440 Denial of Request for Hearing

All Programs

Only the State Office of Administrative Hearings and Rules for the Department of Community Health may deny a request for a hearing. All hearing requests shall be forwarded to the State Office of Administrative Hearings and Rules for the Department of Community Health (refer to Section **400** of this policy).

Medicaid Beneficiary; Mental Health Financial; Mental Health Transfer; WIC Participant, Adult Benefit Waiver Beneficiaries

If the Department or its contract agent believes the State Office of Administrative Hearings and Rules for the Department of Community Health has no jurisdiction to hold a hearing, fax or mail a statement to the State Office of Administrative Hearings and Rules for the Department of Community Health explaining what it is believed to be the legal basis for not granting a hearing.

The State Office of Administrative Hearings and Rules for the Department of Community Health will inform the appellant, the AHR and the Department Representative.

Lead Abatement; Medicaid Provider; Certificate of Need; WIC Vendor

If you believe a request is inappropriate or if the request was filed beyond the required deadline a motion for a hearing denial may be made. To request a hearing denial:

- Prepare a memorandum stating:
  - Why the request should not be heard; or
  - The request was received after the required deadline for filing a hearing request (attach a copy of the notice); and
- Forward the hearing request and memorandum to the State Office of Administrative Hearings and Rules for the Department of Community Health.

- The State Office of Administrative Hearings and Rules for the Department of Community Health will inform the Appellant and Department if the request is denied.

500 Notice of Hearing

Medicaid Beneficiary and Providers; Certificate of Need; Emergency Medical Personnel; Emergency Medical Services; and Health Systems for hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.

The Notice of Hearing will include a docket number, which is an identifier for each hearing.

Notice of the time, date, and place of hearing shall be mailed to the parties, or their authorized hearing representative.

Involuntary Transfer or Discharge from a Nursing Facility

Notice of the time, date and place of hearing will be mailed or faxed to the parties.

510 Place of the Hearing

Medicaid Beneficiaries; Mental Health Financial; WIC Participant; Adult Benefit Waiver Beneficiaries

Hearings are routinely scheduled for telephone conference calls. The Administrative Law Judge conducts the hearing from his/her office. The ALJ will call the Appellant/AHR at the number provided on the Hearing Request form.

The Appellant/AHR may request permission of the State Office of Administrative Hearings and Rules for the Department of Community Health to appear by phone from another location. The request must be made to the State Office of Administrative Hearings and Rules for the Department of Community Health at least one full business day before the hearing.

For Medicaid Beneficiaries and Adult Benefit Waiver Beneficiaries the Appellant/AHR may request that the hearing be conducted in person with the ALJ. The ALJ will travel to the local office, facility, Community Mental Health Services Program office, Area Agency on Aging office or other identified location on the scheduled hearing date.

Lead Abatement; Medicaid Provider; Certificate of Need (CON); Emergency Medical Personnel; Emergency Medical Services; Health Systems; Women, Infants, and Children (WIC) Vendor

Hearings are conducted in the hearing rooms of the Department in Lansing. Occasionally, the State Office of Administrative Hearings and Rules for the Department of Community Health will conduct hearings in other locations at the discretion of the State Office of Administrative Hearings and Rules for the Department of Community Health.

Mental Health Transfer

All hearings are conducted by telephone conference call.

Involuntary Transfer

Hearings are conducted by telephone after concurrence of the appellant.

520 Appearances

All Programs

An Appellant may appear on his or her own behalf.

An Appellant may have an attorney appear on his/her behalf. The attorney must file a written Appearance with the State Office of Administrative Hearings and Rules for the Department of Community Health at least two (2) days before the scheduled hearing.

DCH or its contract agencies may appear through designated staff or attorneys.

Medicaid Beneficiaries and Adult Benefit Waiver Beneficiaries

An Appellant may be represented by an authorized hearing representative (AHR).

The right to be an AHR comes from one of the following sources:

- Written authorization signed by the appellant, giving a person the authority to act for the appellant in the hearing process,
- Court appointed guardian or conservator,

- Legal parent of a minor child,
- An AHR has no right to a hearing, but rather exercises the appellant's right.

530 Adjournments

Medicaid Beneficiaries; Medicaid Providers; Mental Health Financial; Mental Health Transfer; WIC Participant; Adult Benefit Waiver Beneficiaries

The Appellant/AHR or Department may request an adjournment (also called a postponement) of a scheduled hearing for good cause. **Only the** State **Office of Administrative Hearings and Rules for the Department of Community Health can grant or deny a request for an adjournment.**

Emergency Medical Personnel; Certificate of Need; Health Systems for hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.

A party may request an adjournment of a scheduled hearing by motion to the Administrative Law Judge assigned to conduct the hearing. The presiding ALJ will not rule on the motion until the opposing party has an opportunity to be heard on the request. If all parties agree to the adjournment, the ALJ may rule on the request immediately.

Women, Infants, and Children (WIC) Vendor

One opportunity shall be provided to both the Department and the vendor to reschedule the hearing date upon specific request in writing addressed to the Administrative Law Judge. Any further requests for adjournment of the hearing must be by motion and addressed to the Administrative Law Judge and shall be granted only upon a showing of good cause. The Administrative Law Judge shall not rule on the request for adjournment until all parties have had an opportunity to be heard on the request. However, if all parties agree to an adjournment, then the Administrative Law Judge may be so advised by telephone and may rule on the request immediately.

540 New Applications or Requests for Services

Medicaid Beneficiaries

A new application or request for services should not be delayed while a hearing is pending on a previous determination. Process the application or request and notify the beneficiary of your determination, following all

Department policies and procedures. Advise the State Office of Administrative Hearings and Rules for the Department of Community Health if the new determination makes the previously requested hearing unnecessary.

550 Department Representative and Department Contact

Each substantive area or component involved in hearings with the State Office of Administrative Hearings and Rules for the Department of Community Health is required to designate a Department Representative.

Hearing requests received by the State Office of Administrative Hearings and Rules for the Department of Community Health will be faxed to the Department Representative. If there is a change in date or location, the Department Representative will be contacted. The Department Representative will be sent all notices and orders issued by the State Office of Administrative Hearings and Rules for the Department of Community Health.

The purpose of the Department Representative is to serve as a single contact point for the State Office of Administrative Hearings and Rules for the Department of Community Health to communicate regarding procedural aspects of any case. The individual presenting the case to the ALJ is the Department Representative. It is their responsibility to ensure the faxes and papers reach the proper persons.

The Department Contact is the individual in a substantive area identified as responsible for the decision for which the hearing is being held. A copy of the decision and order is mailed to the Department Contact. Any problems arising out of the hearings is directed to the Department Contact.

It is the responsibility of the substantive organization to contact the State Office of Administrative Hearings and Rules for the Department of Community Health with any changes in Department Representatives and/or Department Contacts and to ensure that the State Office of Administrative Hearings and Rules for the Department of Community Health has the proper name of individuals (Department Representative and Department Contact); the correct fax number; phone numbers and addresses for the organization which has taken the action and/or has oversight responsibility for contract agencies.

560 Hearing Summary

A Hearing Summary (Exhibit II) or its equivalent shall be prepared for each hearing: Adult Benefit Waiver, Breast & Cervical Cancer Prevention, Children's Special Health Care Services, Medicaid Client general issue, Community Mental Health, Disenrollment, Elderly & Disabled Waiver, Habilitation & Supports Waiver, Home

Help Services, Medicare Buy-In, Managed Care Exception, Mental Health Financial, Mental Health Transfer, Medical Services Billing, OBRA/PASARR, Office of Medical Affairs, Prior Authorization, First Health Pharmacy, Qualified Health Plan, Substance Abuse Services and Transportation.

The narrative must include all of the following:

- Clear statement of the action and/or decision being appealed, including all programs involved in the action.
- Facts that led to the action, or decision.
- Policy which support the action, or decision.
- Correct address of the Appellant or AHR.
- Description of the documents the DCH or the DCH Contract Agency intends to offer as exhibits at the hearing.

A copy of the hearing summary and all documents and records to be used by DCH or the DCH Contract Agency at the hearing must be mailed to the Appellant and/or AHR and the State Office of Administrative Hearings and Rules for the Department of Community Health **at least seven (7) calendar days before the scheduled hearing**.

Appellants and AHR's have the right to review the case record and obtain copies of documents and materials relevant to the hearing.

570 Pleadings

Certificate of Need

All pleadings must comply with 1996 AACS, R 325.9507 and 9509

Emergency Medical Personnel

All pleadings must comply with 2004 AACS, R 325.22351
All answers must comply with 2004 AACS, R 325.22353

Health Systems

For hearings required by Sections 20165, 20166, 20168, 21799(10),

21799b(2), and 21799c of the Public Health Code

All pleadings must comply with 1981 AACS, R 325.21908.
All answers must comply with 1981 AACS, R 325.21910

Medicaid Providers

All pleadings must comply with 1979 AC, R 400.3412

Women, Infant & Children (WIC) Vendor

All pleadings must be in writing, and contain the vendor's name and vendor number, if any.

580 Withdrawal

Medicaid Beneficiaries; **Mental Health Financial**; **Mental Heath Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries; Lead Abatement; WIC Vendor**

At any time before a final decision is issued, an appellant may withdraw its application or request for a hearing. The withdrawal must be in writing or on the record.

Do not ask for a withdrawal that is based on an action you plan to take in the future. If the DCH/DCH Contract Agency settles the case before the hearing:

- Notify the State Office of Administrative Hearings and Rules for the Department of Community Health that the disputed action has been corrected and that the appellant's concerns have been resolved.

When any issue is still in dispute, do not:

- Suggest that the Appellant or AHR withdraw the request;
  or
- Mail a withdrawal form to the Appellant or AHR unless requested.

Do not ask for a withdrawal that is based on an action you plan to take in the future.

An Appellant or AHR may agree to withdraw the hearing request at anytime during the hearing process. Instruct the Appellant or AHR to fill out the Hearing Request Withdrawal form (DCH-0093, See Exhibit IV) and return it immediately in the postage paid envelope to the State Office of Administrative Hearings and Rules for the Department of Community Health or fax it to (517) 334-9505.

Medicaid Provider; **Certificate of Need; Emergency Medical Personnel; Emergency Medical Services; Health Systems hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code.**

At any time before the Director of the Department of Community Health issues a final decision, a party may withdraw its request for a hearing. The withdrawal must be in writing or on the record.

590 Dismissal

Medicaid Beneficiaries; **Mental Health Financial**; **Mental Heath Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries**

The State Office of Administrative Hearings and Rules for the Department of Community Health may dismiss a request for a hearing if the Appellant/AHR fails to appear at a scheduled hearing without good cause.

Emergency Medical Personnel, Emergency Medical Services; Health Systems; Lead Abatement; Medicaid Provider; Certificate of Need; **WIC Vendor**

An Appellant who fails to appear at the scheduled hearing, or fails to comply with Prehearing orders, waives the right to an administrative hearing and any other review to which he or she might be entitled, and such waiver shall constitute acceptance of the action the Department took or proposes to take. The hearing request will be dismissed.

600 Local Level Appeals (Medicaid Managed Care & PACE)

A. Medicaid Managed Care Beneficiaries

- Medicaid beneficiaries participating in managed care are NOT required to exhaust MCO and PIHP level appeals before they request a hearing. Medicaid beneficiaries may process simultaneous appeals.

- Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP/MCO appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

  - The beneficiary has 45 **calendar days** from the date of the notice of action to request a local appeal.

- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
- The beneficiary may file an appeal with the PIHP/MCO organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than **12 calendar days** from the date of the action, the PIHP/MCO must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP/MCO is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
- Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP/MCO Quality Improvement Program.
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professions with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
    - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
    - Opportunity, before and during the appeal process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process.
    - Opportunity to include as parties to the appeal the beneficiary and his/her representative or the legal representative of a deceased beneficiary's estate.

- Information regarding the right t a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP/MCO must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution.
- The content of a notice of disposition must include explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - The right to request a State fair hearing, and how to do so;
  - The right to request to receive benefits while the State fair hearing is pending, if requested with 12 days of the mailing of the PIHP/MCO notice of disposition, and how to make the request; and
  - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP/MCO's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP/MCO must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP/MCO receives the appeal.
- **Expedited Resolution:** The PIHP/MCO must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working** days after the PIHP/MCO receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP/MCO determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

- The PIHP/MCO may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- If the PIHP/MCO denies a request for expedited resolution of an appeal, it must:
    - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP/MCO receives the appeal;
    - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
    - Give the beneficiary follow up **written notice** within **two (2) calendar days**.
- If the PIHP/MCO **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP/MCO or the State must pay for those services in accordance with State policy and regulations.

B. PACE (Medicaid Beneficiaries)

- PACE organization's written appeal process. The PACE organization must have a formal written appeals process, with specified timeframes for response to address noncoverage or nonpayment of a service.
- Notification of participants. Upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies a request for services or payment, the PACE organization must give a participant written information on the appeals process.
- Minimum requirements. At a minimum, the PACE organization's appeal process must include written procedures for the following:
    - Timely preparation and processing of a written denial of coverage or payment as expeditiously as the participant's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request for reassessment.
    - The interdisciplinary team may extend the 72-hour timeframe for notifying the participant or designated representative of its decision to

approve or deny the request by no more than 5 additional days for either of the following reasons:
    - The participant or designated representative requests an extension.
    - The team documents its need for additional information and how the delay is in the interest of the participant.
  - How a participant files an appeal.
  - Documentation of a participant's appeal.
  - Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal.
  - Responses to, and resolution of, appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after the organization receives an appeal.
  - Maintenance of confidentiality of appeals.
- Notification. A PACE organization must give all parties involved in the appeal the following:
  - Appropriate written notification.
  - A reasonable opportunity to present evidence related to the dispute, in person, as well as in writing.
- Services furnished during appeals process. During the appeals process, the PACE organization must meet the following requirements.
  - For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met:
    - The PACE organization is proposing to terminate or reduce services currently being furnished to the participant.
    - The participant request continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.
  - Continue to furnish to the participant all other required services, as specified in subpart F of this part.
- Expedited appeals process.
  - A PACE organization must have an expedited

appeals process for situations in which the participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute.

- Except as provided in paragraph (f)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.
- The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:
  - The participant requests an extension.
  - The organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

- Determination in favor of participant. A PACE organization must furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.
- Determination adverse to the participant. For a determination that is wholly or partially adverse to the participant, at the same time the decision is made, the PACE organization must notify the following:
  - CMS
  - The State-administering agency.
  - The participant.
- Analyzing appeals information. A PACE organization must maintain, aggregate, and analyze information on appeal proceedings and use the information in the organization's internal quality assessment and performance improvement program.

610 Local "Grievance" (Medicaid Managed Care & PACE)

A. Medicaid Managed Care Beneficiaries

1. Federal regulations provide Medicaid beneficiaries with the right to a local grievance process for issues that are not **"actions"**.

2. Managed Care beneficiary grievances (not actions):

   - Shall be filed with the PIHP/MCO organizational unit approved and administratively responsible for facilitating resolution of the grievance.
   - May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
   - **Do not** have access to the State fair hearing process **unless**, the PIHP/MCO fails to respond to the grievance **within 60 calendar days**. This constitutes an "action", and can be appeals for fair hearing to the DCH State Office of Administrative Hearings and Rules for the Department of Community Health.

3. For each grievance filed by a beneficiary, the PIHP/MCO is required to:
   - Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
   - Acknowledge receipt of the grievance;
   - Log the grievance for reporting to the PIHP/MCO Quality Improvement Program.
   - Ensure that the individual(s) who are making the decision on the grievance were not involved in the previous level review or decision-making.
   - Ensure that the individual(s) who make the decisions on the grievance are health care professions with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
     - Involves clinical issues, or
     - Involves the denial of an expedited resolution of an appeal (of an action).

- Submit the written grievance to appropriate staff including a PIHP/MCO administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP/MCO received the grievance/complaint. The content of the Notice of disposition must include:
  - The results of the grievance process;
  - The date the grievance process was concluded;
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance; and
  - How to access the fair hearing process.

B. PACE Beneficiaries

For the purpose of this part, a grievance is a complaint, either written or oral, expressing dissatisfaction with service, delivery or the quality of care furnished.

- Process to resolve grievances. A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by participants, their family members, or representatives.
- Notification to participants. Upon enrollment, and at least annually thereafter, the PACE organization must give a participant written information on the grievance process.
- Minimum requirements. At a minimum, the PACE organization's grievance process must include written procedures for the following:
  - How a participant files a grievance.
  - Documentation of a participant's grievance.
  - Response to, and resolution of, grievance in a timely manner.
  - Maintenance of confidentiality of a participant's grievance.
- Continuing care during grievance process. The PACE organization must continue to furnish all required services to the participant during the grievance process.
- Explaining the grievance process. The PACE organization must discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.

620 Women, Infants, and Children (WIC) Participant Local Hearings

The Department provides a hearing process through which any individual may appeal a Department or local agency action which results in a claim against the individual for repayment of the cash value of improperly issued benefits or results in the individual's denial of participation or disqualification from the program.

The Department provides a hearing at the local level and permits an individual to appeal a local agency decision to the State Office of Administrative Hearings and Rules for the Department of Community Health.

700 Pre-hearing Conferences

All Programs

The presiding ALJ, upon a request of any party, or on his or her own motion, may order a pre-hearing conference for the purpose of facilitating the dispositions of the matter.

Lead Abatement; Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfer; WIC Vendor; WIC Participant, Adult Benefit Waiver Beneficiaries; Emergency Medical Personnel; Emergency Medical Systems;

The ALJ's will **not** routinely conduct pre-hearing conferences.

Medicaid Provider

A pre-hearing conference with the ALJ is routinely scheduled for all provider hearings, **except** appeals of emergency suspensions and/or terminations of a provider's participation in the Medicaid program.

Certificate of Need

The Certificate of Need Rules at 1996 AACS, R 325.9503(5) provide that the first day of the scheduled hearing shall be used for pre-hearings.

800 Subpoenas

Emergency Medical Personnel; Health Systems; Lead Abatement; Medicaid Beneficiaries; Medicaid Provider; Certificate of Need; WIC Vendor; WIC Participant; Adult Benefit Waiver Beneficiaries

A subpoena may be requested when the Appellant/AHR or Department/DCH Contract Agency requires:

- A person outside the Department to come to a hearing to testify; or
- A document from outside the Department to be offered as evidence in a hearing, only if not available voluntarily.

A subpoena may be requested by sending a written request to the State Office of Administrative Hearings and Rules for the Department of Community Health. This request must include:

- The case name
- The docket number
- The date and time the hearing is scheduled
- The name and address of the person whose testimony is required
- What document is to be subpoenaed
- Why the person's presence and/or the document is needed at the hearing
- How the person's testimony or the document relates to the hearing issue

The requestor is responsible for serving the subpoena.

Allow adequate time to mail or hand-deliver the subpoena.

Department staff is expected to participate in hearings without a subpoena when their testimony is required.

If the Appellant/AHR or DCH/DCH Contract Agency staff responsible for presenting the hearing cannot arrange for the participation of a Department staff member, a memo may be sent to the State Office of Administrative Hearings and Rules for the Department of Community Health giving:

- The name and location of the employee;
- Why the employee's participation is needed, and
- How the employee's testimony relates to the hearing issue.

The State Office of Administrative Hearings and Rules for the Department of Community Health will decide whether to require the employee's participation.

810 Motions

All Programs (Including Emergency Medical Professional)

A party preparing to file motions is required to contact other parties involved in the case to attempt to resolve the matter prior to making a motion. Stipulations should be filed with the State Office of Administrative Hearings and Rules for the Department of Community Health whenever possible.

As far as practicable, Michigan Court Rule (MCR) 2.119 applies to motion practice before the State Office of Administrative Hearings and Rules for the Department of Community Health. No filing fees are required.

The State Office of Administrative Hearings and Rules for the Department of Community Health does not set aside a particular date or time to hear a motion. The State Office of Administrative Hearings and Rules for the Department of Community Health's scheduling clerk must be contacted prior to filing and serving the motion to obtain a hearing date, if one is required. The party making the motion must file and serve appropriate notice of the **hearing on the motion.**

Dispositive motions will be heard the first day of the scheduled hearing unless the ALJ agrees to hear the motion on an earlier date.

Exception: The Certificate of Need rules require that all pre-hearing motions be heard on the first day of the scheduled hearing.

Health Systems hearings required by Sections 20165, 20166, 20168, 21799(10), 21799b(2), and 21799c of the Public Health Code

1981 AACS, R 325.21919 governs motion practice.

Emergency Medical Personnel; Emergency Medical Services.

2004 AACS, R 325.22360 governs motion practice.

820 The Hearing

Medicaid Managed Care Beneficiaries Fair Hearings Process

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- Medicaid beneficiary has the right to request a fair hearing when the PIHP/MCO or its contractor takes an "action", or a grievance request is not acted upon with in **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See Section 300 for Notice information)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP/MCO must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP/MCO must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP/MCO, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate.
- Expedited hearings are available.

Medicaid Beneficiaries; Mental Health Financial; Mental Health Transfer; WIC Participant, Adult Benefit Waiver Beneficiaries

The DCH/DCH Contract Agency and Appellant will each present their position to the ALJ, who will determine whether the actions taken are correct according to fact, law, policy and procedure.

Following any opening statements, the ALJ will direct the DCH/DCH Contract Agency case presenter to explain the position of DCH/DCH Contract Agency. The hearing summary, or highlights of it, may be read into the record at this time. The hearing summary may be used as a guide in presenting the evidence, including the following in planning the case presentation:

- An explanation of the action(s) taken including all programs involved.
- The facts that led to the action.
- A summary of the policy or laws relied upon to take the action.
- Any clarifications by DCH/DCH Contract Agency staff of the policy or laws relied upon in taking the action.

Both the DCH/DCH Contract Agency and the Appellant/AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross examine adverse witnesses, and cross-examine the author of a document offered in evidence. Both parties have a right to present arguments without undue interference.

The Administrative Law Judge (ALJ) must ensure that the record is complete, and may do any of the following:

- Take an active role in questioning of witnesses and parties.
- Assist either side to be sure all the necessary information is presented on the record.
- Order the hearing record to be left open to allow for the submission of evidence.
- Refuse to accept evidence that the ALJ believes is:
    - Unduly repetitious
    - Immaterial
    - Irrelevant
    - Incompetent
- Order a medical assessment to be added to the record at agency expense.

Either party may:

- State on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement; and
- Object to evidence the party believes should not be part of the hearing record.

When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and why it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides in the case being heard.

900 ALJ Decisions

ALL Programs

- Decisions and Orders must be based exclusively on evidence introduced at the hearing.
    - The record must consist only of:
        - The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
        - All papers and requests filed in the proceeding; and
        - The order of the Administrative Law Judge.
- The decision must be in writing and must include:
        - Statement of facts;
        - The regulation, policy, statute, contract, case law supporting the decision; (Conclusions of Law)
        - The reasons for the decision; and
        - Identify supporting evidence.

910 Proposals for Decision

Medicaid Provider; Emergency Medical Services; Emergency Medical Personnel.

The Administrative Law Judge will mail the proposal for decision to the parties, and each party shall have ten calendar days from the date of mailing of the proposed decision to file exceptions to the Department.

Certificate of Need

The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have 20 days from the date of service of the proposal for decision to file exceptions or present written arguments.

Exceptions and written arguments shall be served on all parties, who shall have ten (10) days to file their replies to the exceptions and serve the replies on the parties.

Following review of the record or the proposal for decision, exceptions, and replies, if any, the Director of the Department of Community Health shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

Health Systems hearings required by Sections 20165, 20166, 20168, 21799b(2), and 21799c of the Public Health Code

After the conclusion of a hearing, the ALJ shall deliver, to the Director of the Department of Community Health, the official case file and the ALJ's proposal for decision. The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have ten (10) days from the date of service of the proposal for decision to file exceptions or present written arguments.

Following review of the record or the proposal for decision and exceptions thereto, and replies, if any, the Director shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

If no exceptions are filed, the proposal for decision shall become the file order of the Department unless the director issues her order within 90 days from the date of services of the proposal for decision.

Nursing Home Complaints under MCL 21799(10)

After the conclusion of a hearing, the ALJ shall deliver, to the Director of the State Office of Administrative Hearings and Rules for the Department of Community Health the official case file and the ALJ's proposal for decision. The ALJ shall serve the proposal for decision upon the parties by first-class or certified mail or by personal service. Each party shall have 10 days from the date of service of the proposal for decision to file exceptions or present written arguments.

Following review of the record or the proposal for decision and exceptions thereto, and replies, if any, the Manager of the State Office of Administrative Hearings and Rules for the Department of Community Health's hearings unit shall issue an order stating the findings of fact, conclusions of law, and determination of the appeal. The Department shall serve copies of the order on all parties.

920 Final Decision and Order

Health Systems hearings required by Section 21774 of the Public Health Code.

The ALJ's decision and order is the final determination of the Department.

Medicaid Beneficiaries; Lead Abatement; Mental Health Financial; Mental Heath Transfers; WIC Participant; Adult Benefit Waiver Beneficiaries.

The ALJ's decision and order is the final determination of the Department.

If the DCH fair hearing ALJ reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the PIHP/MCO or the State must pay for those services in accordance with State policy and regulations.

Medicaid Provider hearings required under MCL 400.111f

The ALJ's decision and order is the final determination of the Department.

WIC Vendor

The Final Order constitutes the Department's final decision on the appeal. A copy of the Final Order shall be sent by certified mail or served personally upon the vendor. If the adverse action under review has not already taken effect, the Final Order becomes effective on the date of receipt of the Final Order.

1000 Computation of Time

If any filing deadline falls on a Saturday, Sunday or State holiday, the filing deadline shall be extended to the next business day.

1010 Certification of Compliance with the Judge's Order

Medicaid Beneficiaries; Adult Benefit Waiver Beneficiaries

The State Office of Administrative Hearings and Rules for the Department of Community Health will send the decision and order to the Appellant/AHR and Hearings Coordinator. If the decision and order requires implementation by DCH or a DCH Contract Agency, a DCH-0107, Order Certification form, (Exhibit III), will be sent by the State Office of Administrative Hearings and Rules for the Department of Community Health with the decision and order to the Hearings Coordinator. The DCH-0107 confirms the status of the decision and order's implementation; i.e., when the decision and order has or will be acted upon. It must be returned to the State Office of Administrative Hearings and Rules for the Department of Community Health within ten (10) calendar days of the decision and order mailing date.

Complete and return the DCH-0107 (Exhibit III) within ten (10) calendar days of the mailing date on the hearing decision. Send it to the State Office of Administrative Hearings and Rules for the Department of Community Health to certify the status of implementation. Do this even when the implementation is not yet complete.

If implementation of the decision was incomplete when the yellow copy was sent to the State Office of Administrative Hearings and Rules for the Department of Community Health, fill out and mail the pink copy of the DCH-0107 when you complete implementation. This certifies the completion of implementation.

1020 Rehearing/Reconsideration

Medicaid Beneficiaries; **Mental Health Financial**; **Mental Heath Transfers; WIC Participants**

DCH, a DCH Contract Agency, or the Appellant/AHR may file a written request for a rehearing/reconsideration. The State Office of Administrative Hearings and Rules for the Department of Community Health will grant a rehearing/reconsideration request if it meets specific criteria.

For Medicaid beneficiaries, if it is not likely or possible to meet the mandatory 90-day time frame, the State Office of Administrative Hearings and Rules for the Department of Community Health will ask the Appellant to waive the timeliness requirement in writing to allow the Appellant a rehearing/reconsideration.

An Appellant's request for a rehearing/reconsideration must be sent directly to the State Office of Administrative Hearings and Rules for the Department of Community Health.

The State Office of Administrative Hearings and Rules for the Department of Community Health will grant a rehearing/reconsideration when it is believed that one of the following has occurred:

- There is newly discovered evidence or evidence that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision;
- Typographical errors, mathematical errors, or other obvious error in the hearing decision that affect the substantial rights of the Appellant;
- Failure of the ALJ to address other relevant issues in the hearing decision.
- The original hearing record is inadequate for purposes of judicial review.

DCH/DCH Contract Agency staff or the Appellant/AHR may request a rehearing/reconsideration when it is believed that one of the above situations has occurred. The request shall expressly set forth the reasons for the request.

For Medicaid beneficiary cases, rehearing or reconsideration requests must be received by the State Office of Administrative Hearings and Rules for the Department of Community Health within 30 days of mailing of the Hearing decision and order. For all other cases, request must be made within 60 days from the date of mailing of the Hearing decision and order.

The State Office of Administrative Hearings and Rules for the Department of Community Health will either grant or deny a rehearing/reconsideration and send a written notice of the decision.

If a reconsideration is granted, the decision may be modified without further proceedings. If a rehearing is granted, or if there is a need for further testimony for purposes of reconsideration, the hearing shall be noticed and conducted in the same manner as an original hearing.

Medicaid Providers, Certificate of Need, Emergency Medical Professional, Emergency Medical Services.

The Department of Community Health may order a rehearing on its own motion or on request of a party.

Where for justifiable reasons the record of testimony made at the hearing is found by the agency to be inadequate for purposes of judicial review, the agency on its own motion or on the request of a party shall order a rehearing.

A request for a rehearing shall be filed within 60 days of mailing of the final decision and order. A rehearing shall be noticed and conducted in the same manner as an original hearing. The evidence received at the rehearing shall be included in the record for agency reconsideration and for judicial review. A decision or order may be amended or vacated after the rehearing.

1100 List of Exhibits

Exhibit I	Request for Administrative Hearing form (DCH-0092)
Exhibit II	Hearing Summary form (DCH-0367)
Exhibit III	Order Certification form (DCH-0107)
Exhibit IV	Hearing Request Withdrawal form (DCH-0093)
Exhibit V	Forms Requisition form (DCH-0646)

1120 How to Order Forms

To order Exhibit I – IV listed above, please complete a Forms Requisition (form DCH-0646) (also see Exhibit V) and mail it to:

SOAHR/DCH Forms Distribution
PO Box 30763
Lansing, MI 48909
FAX: 517/334-9505