STATE OF MICHIGAN
ENTERPRISE PROCUREMENT

DTMB
320 S Walnut Street Lansing, MI 48933
P.O. Box 30026, Lansing, MI 48909

CONTRACT CHANGE NOTICE

Change Notice Number **13**
to
Contract Number **MA190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	Various
	Contract Administrator	Kyle London	DTMB
		517-614-3616	
		londonk1@michigan.gov	

CONTRACT SUMMARY			
External Quality Review Organization Services and Customer Satisfaction Survey for Michigan Department of Health and Human Services (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2025
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 AND NET 45		N/A	
ALTERNATE PAYMENT OPTIONS		**EXTENDED PURCHASING**	
☐ P-Card ☐ Direct Voucher (PRC) ☐ Other		☐ Yes ☒ No	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☒	1 Year	☐		September 30, 2026
CURRENT VALUE	**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**		
$30,369,330.78	$8,522,352.00	$38,891,682.78		

DESCRIPTION

Effective August 27, 2025, this contract is exercising the second option year and is increased by $8,522,352. The revised contract expiration date is 09/30/2026.

Please note the State Contract Administrator has been changed to Kyle London.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement approval, and State Administrative Board approval on August 26, 2025.

Program Managers

for

Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
DMVA	Tara Premoe	517-481-7643	PremoeT@michigan.gov
MSP	Victoria Olivarez	517-284-3304	OlivarezV1@michigan.gov
MDHHS	Kimberly Hamilton		HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov
MDHHS	Crystal Williams		WilliamsC69@michigan.gov
MDHHS	Jackie Sproat		SproatJ@michigan.gov
MDHHS	Katarzyna Gruszka		GruszkaK@michigan.gov

STATE OF MICHIGAN
ENTERPRISE PROCUREMENT

Department of Technology, Management, and Budget
320 S. Walnut Street 2nd Floor Lansing, MI 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **12**
to
Contract Number **MA190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Adam Ashley	DTMB
		(517)855-1376	
		ashleya2@michigan.gov	

CONTRACT SUMMARY			
External Quality Review Organization Services and Customer Satisfaction Survey for Michigan Department of Health and Human Services (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 12 Months	September 30, 2025
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 AND NET 45		N/A	
ALTERNATE PAYMENT OPTIONS		**EXTENDED PURCHASING**	
☐ P-Card ☐ Direct Voucher (PRC) ☐ Other		☐ Yes ☒ No	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐		
CURRENT VALUE	**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**		
$30,369,330.78	$0.00	$30,369,330.78		

DESCRIPTION

Effective December 20th, 2024, this contract has added Katarzyna Gruszka as a State Program Manager for MCPD replacing Kimberly Hamilton.

Email: gruszkak@michigan.gov

All other terms, conditions, specifications and pricing remain the same. Per Contractor and agency agreement, and DTMB Central Procurement Services approval

Program Managers

for

Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov
MDHHS	Jackie Sproat	517-241-9438	SproatJ@michigan.gov
MDHHS	Crystal Williams	517-284-1252	williamsc69@michigan.gov
MDHHS	Katarzyna Gruszka		GruszkaK@michigan.gov

STATE OF MICHIGAN
ENTERPRISE PROCUREMENT

Department of Technology, Management, and Budget
320 S. Walnut Street 2nd Floor Lansing, MI 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **11**
to
Contract Number **MA190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Adam Ashley	DTMB
		(517)855-1376	
		ashleya2@michigan.gov	

CONTRACT SUMMARY			
External Quality Review Organization Services and Customer Satisfaction Survey for Michigan Department of Health and Human Services (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 12 Months	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 AND NET 45		N/A	
ALTERNATE PAYMENT OPTIONS		**EXTENDED PURCHASING**	
☐ P-Card ☐ Direct Voucher (PRC) ☐ 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	☐		September 30, 2025
CURRENT VALUE	**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**		
$21,236,855.05	$9,132,475.73	$30,369,330.78		

DESCRIPTION
Effective September 4, 2024, the following changes are hereby incorporated into this contract. 1. $9,132,475.73, and Schedule B - Pricing are added to the SOW added with CN 10. 2. 1 option year on this contract is hereby exercised; the revised contract expiration date is 9/30/25. 3. The Contract Administrator has been changed to Adam Ashley ashleya2@michigan.gov / (517) 855-1376 All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement approval, and State Administrative Board approval on 8/20/24.

Program Managers

for

Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kimberly Hamilton		HamiltonK@michigan.gov
MDHHS	Crystal Williams		WilliamsC69@michigan.gov
MDHHS	Jackie Sproat		SproatJ@michigan.gov

Task Name/Description	FY2025 Unit Price	# of units	FY2025 Total Price	Assumptions
NCI Consumer Survey	$ 300,300	1	$ 300,300	MI-DDI will complete a minimum of 660 National Core Indicators (NCI) interviews.
Compliance Review - MHP [New]	$ 22,640	9	$ 203,760	Review will focus on federally-required standards and state-aligned contract requirements.
Compliance Review - DHP [New]	$ 22,640	2	$ 45,280	Review will focus on federally-required standards and state-aligned contract requirements.
Compliance Review - PIHP	$ 22,640	10	$ 226,400	Review will focus on federally-required standards and state-aligned contract requirements.
Readiness Review Operations and Information Systems Review [New]	$ 205,818	9	$ 1,852,362	Cost is per each new plan who will require a readiness review (up to 9 plans). The review will adhere to Medicaid expectations under 42 CFR §438.66, with a review of key integrated concepts (e.g., Appeals and Grievances, Member Materials, Enrollment Processes). Budget includes travel costs.
Readiness Review Financial Management [New]	$ 25,606	9	$ 230,454	Cost is per each new plan who will require a readiness review (up to 9 plans). The review will adhere to expectations under 42 CFR §438.66 for the financial management component. The review will be conducted through a desk review.
Technical Report - MHP	$ 12,761	9	$ 114,849	The report will include all mandatory and optional external quality review activities. The price per unit assumes five (5) to ten (10) plans.
Technical Report - DHP	$ 19,142	2	$ 38,284	The report will include all mandatory and optional external quality review activities. The price per unit assumes one (1) to four (4) plans.
Technical Report - PIHP	$ 12,761	10	$ 127,610	The report will include all mandatory and optional external quality review activities. The price per unit assumes five (5) to ten (10) plans.
Technical Report - ICO	$ 12,761	6	$ 76,566	The report will include all mandatory and optional external quality review activities. The price per unit assumes five (5) to ten (10) plans.
Technical Report - Waiver Agency	$ 10,909	19	$ 207,271	The report will include all mandatory and optional external quality review activities. The price per unit assumes eleven (11) to twenty (20) plans.
PIPs - Comprehensive Health Care Program Medicaid Health Plan (MHP)	$ 8,232	18	$ 148,176	Per unit cost, is per each PIP and assumes one (1) clinical and one (1) non clinical PIP will be validated for each plan.
PIPs Healthy Kids Dental/Dental Health Plan (DHP)	$ 8,232	4	$ 32,928	Per unit cost, is per each PIP and assumes one (1) clinical and one (1) non clinical PIP will be validated for each plan.
PIPs Behavioral Health Prepaid Inpatient Health Plan (PIHP)	$ 8,232	20	$ 164,640	Per unit cost, is per each PIP and assumes one (1) clinical and one (1) non clinical PIP will be validated for each plan.
PIPs MI Health Link Integrated Care Organizations (ICOs)	$ 8,232	6	$ 49,392	Per unit cost, is per each PIP and assumes one (1) PIP will be validated for each plan.
PIPs MI Choice Prepaid Ambulatory Health Plans (PAHPs)- [New]	$ 8,232	38	$ 312,816	Per unit cost, is per each PIP and assumes one (1) clinical and one (1) non clinical PIP will be validated for each plan.
Waiver Agency Consumer Guide [New]	$ 52,160	1	$ 52,160	Activity is reflective of one (1) consumer guide to include all plans.
MHP Consumer Guide	$ 42,481	1	$ 42,481	Activity is reflective of one (1) consumer guide to include all plans.
HKD (DHP) Consumer Guide	$ 32,749	1	$ 32,749	Activity is reflective of one (1) consumer guide to include all plans.
EDV- Comparative Analysis - MHPs	$ 27,912	9	$ 251,208	Cost per unit is reflective of scope of work change for SFY2025, assuming five (5) or more plans.
EDV- Comparative Analysis - PIHPs	$ 27,912	10	$ 279,120	Cost per unit is reflective of scope of work change for SFY2025, assuming five (5) or more plans.
EDV- Comparative Analysis - ICOs	$ 27,912	6	$ 167,472	Cost per unit is reflective of scope of work change for SFY2025, assuming five (5) or more plans.
EDV- Comparative Analysis - HKD	$ 33,458	2	$ 66,916	Cost per unit is reflective of scope of work change for SFY2025, assuming one (1) to four (4) plans.
EDV- Comparative Analysis - PAHPs	$ 27,912	19	$ 530,328	Cost per unit is reflective of scope of work change for SFY2025, assuming five (5) up to nineteen (19) plans.
Child MHP CAHPS	$ 26,495	9	$ 238,455	Cost per unit assumes seven (7) to ten (10) plans. No change in scope from SFY2024.
Adult MHP CAHPS	$ 6,657	1	$ 6,657	Activity is reflective of one (1) aggregate report to include all MHPs. No change in scope from the SFY2024
Child FFS CAHPS	$ 27,840	1	$ 27,840	No change in scope from SFY2024.

Adult FFS CAHPS	$ 25,421	1	$ 25,421	No change in scope from SFY2024.
CSHCS MHP CAHPS	$ 19,771	9	$ 177,939	Cost per unit assumes a minimum of seven (7) to ten (10) plans. No change in scope from SFY2024.
CSHCS FFS CAHPS	$ 22,395	2	$ 44,790	Per unit cost assumes each CSHCS FFS population sample.
Statewide CCC CAHPS- [New]	$ 82,214	1	$ 82,214	Assumes one (1) statewide CCC CAHPS sample.
HCBS ADULT CAHPS- ICO	$ 238,458	1	$ 238,458	Entire eligible population is surveyed due to the small number of members within the survey population.
HMP Dental CAHPS	$ 20,441	9	$ 183,969	Cost per unit assumes seven (7) to ten (10) plans. No change in scope from SFY2024.
HKD Dental CAHPS	$ 34,465	2	$ 68,930	Cost per unit assumes two (2) to three (3) plans. No change in scope from SFY2024.
MHP Secret Shopper Surveys	$ 30,306	9	$ 272,754	Cost per unit assumes seven (7) to ten (10) plans. No change in scope from SFY2024.
HKD Secret Shopper Surveys	$ 68,495	2	$ 136,990	Cost per unit assumes two (2) to three (3) plans. No change in scope from SFY2024.
ICO Secret Shopper Surveys	$ 21,018	6	$ 126,108	Cost per unit assumes four (4) to six (6) plans. No change in scope from SFY2024.
PIHP Performance Measure Validation	$ 18,226	10	$ 182,260	No change in scope from SFY2024.
ICO Performance Measure Validation	$ 25,845	6	$ 155,070	No change in scope from SFY2024.
PAHP (Waiver Agencies) Performance Measure Validation - [New]	$ 23,419	19	$ 444,961	Audit will be conducted virtually and will include two hybrid performance measures.
MHP HEDIS Reporting	$ 17,161	9	$ 154,449	No change in scope from SFY2024.
HKD Performance Measure Validation and PM Aggregate Reporting	$ 67,458	2	$ 134,916	Combined PMV & PM Aggregate Reporting into one activity
Network Adequacy Validation-HKD	$ 57,076	2	$ 114,152	No change in scope from SFY2024.
Network Adequacy Validation-MHP	$ 36,010	9	$ 324,090	No change in scope from SFY2024.
Network Adequacy Validation-PAHP/Waiver Agencies	$ 32,689	19	$ 621,091	No change in scope from SFY2024.
Network Adequacy Validation-PIHP	$ 35,395	10	$ 353,950	No change in scope from SFY2024.
Network Adequacy Validation - ICO	$ 37,475	6	$ 224,850	No change in scope from SFY2024.
Transition to HIDE-SNP Quality Measures Reporting Requirements [New]	$ 105,521	1	$ 105,521	1. Develop data collection templates for up to 16 measures, using the most recent version of the MMP Core Reporting Requirements and the MMP Michigan State-specific Reporting Requirements vs creating any new reporting requirements. 2. Assist MDHHS in development of data submission instructions 3. Develop reporting requirements for up to 18 measures 4. Provide minimal Technical Assistance in SFY2025 5. MDHHS to own data collection process and procedures
TOTAL FY2025 Price			**$ 9,999,357**	

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **10**

to

Contract Number **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Jordana Sager	DTMB
		(517) 896-1903	
		sagerj2@michigan.gov	

CONTRACT SUMMARY

EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
.05NET30 AND NET 45	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ PRC	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		N/A

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$20,974,270.05	$262,585.00	$21,236,855.05

DESCRIPTION

Effective December 12, 2023, the following technical reporting activities for MDHHS required by CMS and $262,585 to fund this work is hereby added to the Contract:

1. MI Choice External Quality Review (EQR)Technical Report - $201,781
2. Healthy Kids Dental Program PMV for SFY 2024 - $60,804

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement approval, and State Administrative Board approval on December 12, 2023.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov
MDHHS	Crystal Williams	517-284-1252	williamsc69@michigan.gov
MDHHS	Jackie Sproat	517-241-9438	SproatJ@michigan.gov

Health Services Advisory Group, Inc.
Michigan Department of Health and Human Services (MDHHS)
Healthy Kids Dental Performance Measure Validation (PMV) for State Fiscal Year (SFY) 2024

Project	Description	Assumptions	Proposed Cost for SFY 2024 Report
Healthy Kids Dental Program PMV for SFY 2024	For SFY 2024, HSAG will validate the performance measure rates generated by the two participating Dental Health Plans (DHPs) that are contracted with MDHHS during the preceding Federal Fiscal Year defined in the Centers for Medicare & Medicaid Services (CMS) Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report (i.e., CMS-416 EPSDT performance measures) and Dental Quality Alliance Dental Quality Measures in accordance with 42 CFR § 438.330(b)(2). The PMV will follow the same processes used during SFY 2023.	1. HSAG will validate up to seven (7) CMS-416 EPSDT performance measure rates and up to two (2) Dental Quality Alliance Dental Quality Measures for the specified population in accordance with the applicable performance measure technical specifications. This process assumes one (1) rate submisson for each DHP. 2. HSAG shall follow the most current version of the CMS External Quality Review (EQR) Protocol 2: Validation of Performance Measures guidelines and the agreed upon MDHHS timeline, when conducting the PMV. 3. HSAG will conduct a virtual validation of two DHPs based on the performance meaure rate reporting process. 4. HSAG will produce two final DHP-specific PMV reports.	$ 60,804

Health Services Advisory Group, Inc.
Michigan Department of Health and Human Services (MDHHS)
MI Choice External Quality Review Technical Report for State Fiscal Year (SFY) 2024

Project	Description	Assumptions	Proposed Cost for SFY 2024 Report
MI Choice External Quality Review (EQR)Technical Report	The MI Choice EQR Technical Report will adhere to the requirements outlined in 42 CFR § 438.364. For the SFY 2024 MI Choice EQR Technical Report, HSAG will add the Network Adequacy Validation and Encounter Data Validation activities.	HSAG assumed the following when developing the cost proposal: a comprehensive assessment will be completed of each of the 20 MI Choice PAHPs (Waiver Agencies) using data supplied by MDHHS and information extracted from the MDHHS website for Performance Improvement Projects, Performance Measure Validation, Compliance Reviews, and Consumer Surveys (CAHPS.) For the SFY 2024 report, HSAG will add data for Network Adequacy Validation and Encounter Data Validation using the data obtained through the EQR work conducted by HSAG. Additionally, the report will include a comparison of the PAHPs and the overall performance of the MI Choice program related to the quality, access, and timeliness of services provided to waiver members. HSAG will also provide detailed and meaningful recommendations to MDHHS for improving the MI Choice program.	$ 201,781

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget

320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **9**

to

Contract Number **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Jordana Sager	DTMB
		(517) 896-1903	
		sagerj2@michigan.gov	

CONTRACT SUMMARY

EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
.05NET30 AND NET 45	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ PRC	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		N/A

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$19,557,691.05	$1,416,579.00	$20,974,270.05

DESCRIPTION

Effective September 28, 2023, the attached Schedule A - Statement of Work is added to the Contract for use by MDHHS for the Validation of Network Adequacy obligations stipulated in the CMS External Quality Review and $1,416,579.00 is being added for these activities.

Please note: Jackie Sproat is replacing Kathy Haines as one of the State's Program Manager (PM) on this Contract.

Jackie Sproat
320 South Walnut Street
Lansing MI 48933
SproatJ@michigan.gov
517-241-9438

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement approval, and State Administrative Board approval on September 28, 2023.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov
MDHHS	Crystal Williams	517-284-1252	williamsc69@michigan.gov
MDHHS	Jackie Sproat	517-241-9438	SproatJ@michigan.gov

Statement of Work – MDHHS

CN 9 - 190000001404

Scope

The Contractor will perform the following activities required to meet the Validation of Network Adequacy requirements stipulated in the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocol 4.[1] The Validation of Network Adequacy, also referred to as Network Adequacy Validation (NAV), scope of work, associated high-level timeline, and cost estimate are detailed in this document. The NAV activities outlined in this proposal are limited to a NAV evaluation of the following health plans:

- Six MI Health Link Integrated Care Organizations (ICOs)
- Nine Medicaid Health Plans (MHPs)
- Two Dental Health Plans (DHPs)
- 10 Prepaid Inpatient Health Plans (PIHPs)
- 20 MI Choice Prepaid Ambulatory Health Plans (PAHPs) called waiver agencies

The Contractor uses the term "health plan" to describe the contracted entities across all lines of business. **The NAV findings derived from this evaluation will be reported in the CMS EQR Technical Report due to CMS in April 2025.**

Scope of Work

To fulfill the requirements of CMS EQR Protocol 4, HSAG will perform the necessary NAV activities to assess and validate the network adequacy of each health plan. To maximize the utility of the current activities being conducted, the Contractor will employ a NAV **audit validation** approach for the MHPs, DHPs, PIHPs, and PAHPS, and a NAV **analytic validation** approach for the ICOs.

Network Standards and Indicators

The Contractor will work with the Michigan Department of Health and Human Services (MDHHS) to evaluate the geographic access standards by provider type identified by MDHHS. The complete list of standards to be evaluated for each managed care entity (MCE) type is shown in Appendix A. These standards will be evaluated by provider type and stratified by urban and rural geographic designations, as appropriate.

The Contractor will work with MDHHS to determine a final provider crosswalk after initiation of the formal NAV audit process. HSAG will also work with MDHHS to identify the required NAV-related data sources to be included in the audit.

Provider Network Information Systems and Data Sources for Validation

The Contractor will submit a document request packet to each health plan that outlines the information required to conduct the NAV audit. The document request packet will require the health plan to submit all of the information necessary to facilitate the NAV audit, which includes, but is not limited to, the following:

- Information systems documentation for all systems utilized to monitor network adequacy
- Network adequacy indicator rates for each standard required by MDHHS, including any associated data required to validate each rate

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[1] Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR) Protocols. February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Page 207–238. Accessed on: Jun 22, 2023.

- NAV source code utilized to calculate the rates

The Contractor will use the comprehensive Information Systems Capabilities Assessment Tool (ISCAT) to collect and evaluate the capabilities of each health plan's information systems infrastructure to monitor network standards in accordance with the requirements of CMS EQR Protocol 4. In preparation for the virtual audit, the Contractor will evaluate the health plan-reported indicator rates for each standard and the corresponding source code provided.

Virtual Audit to Review Information Systems Underlying Network Adequacy Monitoring

For the audit validation approach, the Contractor will conduct a virtual audit with each health plan. The virtual audit will include the following types of activities:

- Review of the ISCAT and other documentation submitted by the health plan in response to HSAG's document request packet
- Verification of data sources and the corresponding information systems that house each data source
- Live demonstration by the health plan of its information systems used to monitor network adequacy
- Evaluation of data management processes for all data related to network adequacy monitoring
- Primary source verification of data in the health plan's information systems
- Process discussions with health plan staff related to network adequacy standard monitoring and indicator rate calculations
- Exit conference discussing findings and next steps in the NAV audit process

Validate Plan-Submitted Network Adequacy Data and Results

For the audit validation approach, the Contractor will review and validate the health plan NAV data submitted to ensure its accuracy, completeness, and consistency. Through this process, the Contractor will evaluate each health plan's ability to:

- Collect, capture, and monitor valid network adequacy data
- Evaluate the adequacy of the provider network using sound analytic methods
- Produce accurate results to support managed care organization (MCO) network adequacy monitoring
- Provide MDHHS with accurate network adequacy indicator rates for each required standard

At the conclusion of this step, the Contractor will calculate a validation rating for each network adequacy indicator for each health plan. The approach employed by the Contractor to derive the validation ratings will align with the requirements stipulated in CMS EQR Protocol 4.

Analytic Validation for ICOs

For the ICOs, the Contractor will perform an analytic validation of the network adequacy findings submitted by the ICOs. For the ICOs, the Contractor will:

- Review the ISCAT and other documentation submitted by the health plan in response to the Contractor's document request packet
- Verify data sources and the corresponding information systems that house each data source
- Evaluate the data management processes for all data related to network adequacy monitoring
- Calculate the network adequacy standards using data supplied by the ICO and MDHHS and compare those results with results supplied by the ICOs

At the conclusion of this analytic validation, the Contractor will calculate a validation rating for each network adequacy indicator for the ICOs that accounts for results from the ISCAT and the analytic validation of the network adequacy metrics.

Reporting

The Contractor will generate one NAV Audit Aggregate Report for MDHHS at the conclusion of the NAV activity with results presented separately for the ICOs, MHPs, DHPs, PIHPs, and PAHPs. No health plan-specific NAV reports will be generated; however, individual health plan results will be included in the following sections of the NAV Audit Aggregate Report:

- Findings of ISCA/Data Validity
- Analysis and Conclusions for NAV
- Recommended Improvements
- Appendix

During future reporting cycles, the Contractor will also incorporate an evaluation of progress made by the health plans from the prior year on the network standards.

Additional Activities

The cost of this statement of work also includes the NAV activities currently in EQRO Contract Year 5 for the ICOs, MHPs, and DHPs. It includes a breakout of the cost of the current activities from the cost of the additional activities required to comply with CMS Protocol 4.

Timeline

The following high-level timeline reflects NAV activities beginning in Fall 2023. The NAV results will be included in the EQR Technical Report due to CMS in April 2025. Detailed timelines, including specific analytic validation steps for the ICOs, will be provided in the Contract Year 5 project work plans.

Activity	Time Frame
Finalize Provider Network Standards, Indicators, and Provider Crosswalk	2–3 months
Identify Data Sources for the Network Adequacy Validation Audit	1 month
Receive Completed Comprehensive ISCAT Inclusive of Provider Network Information Systems and Data Sources for Validation, and Perform Virtual Audit to Review Information Systems Underlying Network Adequacy Monitoring	2–3 months
Validate Plan-Submitted Network Adequacy Data and Results	2–3 months
Submit Draft Report to MDHHS and the health plans	1 month
Submit Final Report to MDHHS and the health plans	1 month

Schedule B - Pricing

The following sections outlines the cost proposal for each type of managed care entity. A list of assumptions is included at the end of the cost proposal.

ICOs

The Contractor will continue to calculate network adequacy indicator rates and conduct secret shopper calls. The Contractor will add network adequacy **analytic validation** of the 6 ICOs to meet CMS Protocol 4 requirements. The table below provides the Contract Year 5 NAV cost proposal for the ICOs.

Activity	Contract Info	Amount
Network Adequacy Calculations and Secret Shopper Calls	Year 5 Current Contract	$231,718.45
Network Adequacy Analytic Validation	Year 5 Additional Funding Required	$93,152.00
Grand Total - ICOs	**Year 5**	**$324,870.45**

MHPs

The Contractor will continue to conduct network validation surveys for the MHPs. The Contractor will add network adequacy **audit validation** of the 9 MHPs to meet CMS Protocol 4 requirements. The table below provides the Contract Year 5 NAV cost proposal for the MHPs.

Activity	Contract Info	Amount
Network Adequacy Validation Surveys	Year 5 Current Contract	$250,599.80
Network Adequacy Audit Validation	Year 5 Additional Funding Required	$296,558.00
Grand Total - MHPs	**Year 5**	**$547,157.80**

DHPs

The Contractor will continue to conduct network validation surveys for the DHPs in HKD. HSAG will add network adequacy **audit validation** of the 2 DHPs to meet CMS Protocol 4 requirements. The table below provides the Contract Year 5 NAV cost proposal for the DHPs.

Activity	Contract Info	Amount
Network Adequacy Validation Surveys	Year 5 Current Contract	$125,858.47
Network Adequacy Audit Validation	Year 5 Additional Funding Required	$104,485.00
Grand Total - DHPs	**Year 5**	**$230,343.47**

PIHPs

The Contractor does not currently conduct network adequacy-related activities for the PIHPs. HSAG will add network adequacy **audit validation** of the 10 PIHPs to meet CMS Protocol 4 requirements. The table below provides the Contract Year 5 NAV cost proposal for the PIHPs.

Activity	Contract Info	Amount
Network Adequacy Audit Validation	Year 5 Additional Funding Required	**$323,997.00**

PAHPs

The Contractor does not currently conduct network adequacy-related activities for the PAHPs. HSAG will add network adequacy **audit validation** of the 20 PAHPs to meet CMS Protocol 4 requirements. The table below provides the Contract Year 5 NAV cost proposal for the PAHPs.

Activity	Contract Info	Amount
Network Adequacy Audit Validation	Year 5 Additional Funding Required	**$598,387.00**

Summary of Additional Costs

The following table summarizes the additional cost per population to meet the CMS Protocol 4 requirements for Contract Year 5.

Activity	Units	Amount
MHPs—Network Adequacy Audit Validation	9	$296,558
DHPs—Network Adequacy Audit Validation	2	$104,485
ICOs—Network Adequacy Analytic Validation	6	$93,152
PIHPs—Network Adequacy Audit Validation	10	$323,997
PAHPs—Network Adequacy Audit Validation	20	$598,387
Grand Total of Additional Validation		**$1,416,579**

Assumptions

The Contractor's cost are based on the following assumptions:

1. Limited to the evaluation of the number of plans listed under each MCE's pricing. The inclusion of additional health plans will necessitate re-pricing.
2. Limited to the evaluation of the network adequacy standards provided by MDHHS and listed in Appendix A. The inclusion of additional standards may necessitate re-pricing.
3. All NAV activities will be performed virtually with no travel required.
4. Health plans will submit complete information and data in a timely manner. Delayed and/or multiple health plan resubmissions may necessitate additional funding to complete the NAV activity and may jeopardize MDHHS' ability to meet the April 2025 CMS EQR Technical Report reporting requirement.

5. Deliverables will include:
    a. Draft Aggregate Report
    b. Final Aggregate Report
6. No health plan-specific reports will be produced.
7. Results included in the Final Aggregate Report will also be incorporated into the EQR Technical Report due to CMS in April 2025.

Cost proposal is only for the results due in the April 2025 Technical Report, it does not include any validation of network adequacy activities that are required for the EQR Technical Report due to CMS in April 2026 (i.e., the proposal is limited to EQRO Contract Year 5).

Appendix A

Table A-1 below lists the network adequacy standards that HSAG will evaluate for the ICOs.

Table A-1: Network Adequacy Standards and Associated Provider Types for ICOs

Standard	Provider Types
The ICO must have at least two (2) available providers for each provider type with sufficient capacity to accept enrollees.	• Dental (preventive and restorative) • NEMT • Eye Wear and Eye Examinations • Hearing Aids and Hearing Examinations • LTSS: Adult Day Care Chore Services • Environmental Modifications • Expanded Community Living Supports • Non-Medical Transportation • Personal Care Services • Preventive Nursing Services • Private Duty Nursing • Respite • Adaptive Medical Equipment & Supplies • Assistive Technology—Devices • Assistive Technology—Van Lifts and Tie Downs • Community Transition Services • Fiscal Intermediary • Home Delivered Meals • Medical Supplies • Personal Emergency Response System
For services provided in the community, the ICO must assure that the Enrollee does not travel more than thirty (30) miles or for more than thirty (30) minutes to receive the service.	• Adult Day Program • Dental (preventive and restorative) • NEMT • Eye Wear and Eye Examinations • Hearing Aids and Hearing Examinations
Appointment and Timely Access to Dental Care Standards	• Dental (preventive and restorative)
Appointment and Timely Access to Specialty Care Standards	• Hearing and Eye Examinations
The ICO shall ensure that Maternal Infant Health Program (MIHP) services are available to qualifying Enrollees and include MIHP providers within the ICO network, in accordance with published Michigan Medicaid Policy.	• MIHP Agencies

Table A-2 below lists the network adequacy standards that HSAG will evaluate for the MHPs.

Table A-2: Network Adequacy Standards and Associated Provider Types for MHPs

Standard	Provider Types
Time and Distance Standards	• Primary Care Providers (adult) • Primary Care Providers (pediatric) • Obstetrics and Gynecology (OB/GYN) • Cardiology • Outpatient Behavioral Health • Hospital • Pharmacy • General Dentistry
Maximum Provider: Enrollee Ratios	• Primary Care Providers (adult) • Primary Care Providers (pediatric) • General Dentistry

Table A-3 below lists the network adequacy standards that HSAG will evaluate for the DHPs.

Table A-3: Network Adequacy Standards and Associated Provider Types for DHPs

Standard	Provider Types
Time and Distance Standards	• General Dentistry • Endodontist • Oral Surgeon • Pediatric Dentist • Periodontist • Prosthodontist
Maximum Provider: Enrollee Ratios	• General Dentistry

Table A-4 below lists the network adequacy standards that HSAG will evaluate for the PIHPs.

Table A-4: Network Adequacy Standards and Associated Provider Types for PIHPs

Standard	Provider Types
Time and Distance Standards	• Inpatient Psychiatric Services (Adult and Pediatric) • All Other Select Behavioral Health (BH) Services (Adult and Pediatric)
Maximum Provider: Enrollee Ratios	• Assertive Community Treatment (Adult) • Psychosocial Rehabilitation Clubhouses (Adult) • Opioid Treatment Programs (Adult) • Crisis Residential (Adult) • Home-Based (Pediatric) • Wraparound (Pediatric) • Crisis Residential (Pediatric)

Table A-5 below lists the network adequacy standards that HSAG will evaluate for the PAHPs.

Table A-5: Network Adequacy Standards and Associated Provider Types for PAHPs

Standard	Provider Types
Time and Distance Standards	• Adult day health (adult day care) • Chore services • Community health worker • Community living supports • Community transportation • Counseling • Environmental accessibility adaptations • Fiscal intermediary • Goods and services • Home delivered meals • Nursing services • Personal emergency response systems (PERS) • Private duty nursing/respiratory care • Respite services • Specialized medical equipment and supplies • Training in a variety of independent living skills
Network Capacity Standards (i.e., at least two providers in each MI Choice service area)	• Adult day health (adult day care) • Chore services • Community health worker • Community living supports • Community transportation • Counseling • Environmental accessibility adaptations • Fiscal intermediary • Goods and services • Home delivered meals • Nursing services • Personal emergency response systems (PERS) • Private duty nursing/respiratory care • Respite services • Specialized medical equipment and supplies • Training in a variety of independent living skills

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **8**

to

Contract Number **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Jordana Sager	DTMB
		(517) 896-1903	
		sagerj2@michigan.gov	

CONTRACT SUMMARY

EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
.05NET30 AND NET 45	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ PRC	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		N/A

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$19,537,404.05	$20,287.00	$19,557,691.05

DESCRIPTION

Effective 1/23/2023, this contract is hereby increased by $20,287.00 for General Technical Assistance for Performance Measures for MDHHS.

All other terms, conditions, specifications and pricing remain the same. Per contractor and agency agreement, and DTMB Central Procurement approval.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
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CONTRACT CHANGE NOTICE

Change Notice Number **7**

to

Contract Number **190000001404**

CONTRACTOR	
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CONTRACT SUMMARY

EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
.05NET30 AND NET 45	

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ PRC	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		September 30, 2024

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$16,356,796.05	$3,180,608.00	$19,537,404.05

DESCRIPTION

Effective 1/3/23, this contract is hereby increased by a total of $3,180,608 for the deliverables added in Change Notice #6,

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement approval, and State Administrative Board approval on January 3, 2023.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

Schedule B - Pricing

Table 1—SFY 2023 Information Systems Review and Administrative Profile Cost Estimate

Project/Program	Number of Plans	Proposed Cost
Information Systems Review/Administrative Profile - Medicaid Health Plans	9	$254,628
Information Systems Review/Administrative Profile - Prepaid Inpatient Health Plans	10	$282,366
Information Systems Review/Administrative Profile - Integrated Care Organizations	6	$176,127
Information Systems Review/Administrative Profile - Prepaid Ambulatory Health Plans (Dental Health Plans)	2	$67,983
Information Systems Review/Administrative Profile - Prepaid Ambulatory Health Plans (Waiver Agencies)	20	$551,056
Total	**47**	**$1,332,160**

Table 2—SFY 2024 Medical Record Review Cost Estimate

Project/Program	Number of Plans	Proposed Cost
Medical Record Review - Medicaid Health Plans	9	$340,754
Medical Record Review - Prepaid Inpatient Health Plans	10	$380,150
Medical Record Review - Integrated Care Organizations	6	$236,667
Medical Record Review - Prepaid Ambulatory Health Plans (Dental Health Plans)	2	$89,455
Medical Record Review - Prepaid Ambulatory Health Plans (Waiver Agencies)	20	$744,060
Total	**47**	**$1,791,086**

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **6**

to

Contract Number **190000001404**

CONTRACTOR	
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STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Jordana Sager	DTMB
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CONTRACT SUMMARY			
EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 AND NET 45			
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-Card	☐ PRC	☐ Other	☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐		September 30, 2024
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$16,356,796.05	$0.00		$16,356,796.05	

DESCRIPTION

Effective 1/3/23, the updated Section 1.5 including provisions (F) and (G) are hereby incorporated into the contract. Please note the State Contract Administrator has been changed to Jordana Sager.

All other terms, conditions, specifications and pricing remain the same. Per contractor and agency agreement, and DTMB Central Procurement approval.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

PERFORMANCE MEASURE VALIDATION

1. Starting in State Fiscal Year (SFY) 2023, HSAG shall annually validate the performance measure rates generated by the two participating Dental Health Plans (DHPs) that are contracted with MDHHS during the preceding Federal Fiscal Year defined in the Centers for Medicare & Medicaid Services (CMS) Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report (i.e., CMS-416 EPSDT performance measures) in accordance with 42 CFR § 438.330(b)(2).
2. HSAG shall serve as the certified auditor for MDHHS and validate up to seven (7) CMS-416 EPSDT performance measure rates for the specified population in accordance with the applicable performance measure technical specifications.
3. HSAG shall follow the most current version of the CMS External Quality Review (EQR) Protocol 2: Validation of Performance Measures guidelines and the agreed upon MDHHS timeline, when conducting performance measure validation (PMV).
4. HSAG will conduct a virtual validation of two DHPs based on the performance measure rate reporting process.
5. Main steps of the validation will include the following:
    a. An assessment of the integrity of the DHPs' information systems using the Information Systems Capabilities Assessment Tool (ISCAT) to evaluate core administrative systems (i.e., enrollment/eligibility, provider, and claims/encounter), supplemental data sources (if applicable), and data integration and calculation systems and processes.
    b. A detailed review of the source code and programming logic used to report and calculate each measure.
    c. A virtual audit review where HSAG's lead auditor conducts interviews with the DHPs' key personnel who demonstrate information systems and processes used to collect, manage, produce, and report performance measures.
    d. Pre-virtual audit review selection and review of case-specific proof-of-service documents and live primary source verification during the virtual audit review will also be conducted by an HSAG auditor.
    e. A formal assessment of and audit designation for the DHPs' reported rates.
    f. The production of two final DHP-specific PMV reports.

ASSUMPTIONS

1. Assuming one (1) rate submission for each DHP, with up to seven (7) measures reported in each.

2. No travel is budgeted since the reviews will be performed virtually.
3. A Certified-(HEDIS®)1 Compliance Auditor (CHCA) will maintain oversight and accountability for the audits, while assigned HSAG auditors conduct the virtual reviews.

DELIVERABLES

HSAG will complete the following deliverables:
Two (2) final PMV audit reports to be created and distributed to MDHHS and the applicable DHPs.

MICHIGAN ENCOUNTER DATA VALIDATION

1. Accurate and complete encounter data are critical to the success of a managed care program. HSAG understands that validation of encounter data (EDV) is critical to ensuring that data submitted are complete and accurate reflections of the care provided to Medicaid beneficiaries—a necessary requirement so reports, quality measures, and capitation payment rates developed from the data are reliable and comparable across all Managed Care Entities (MCEs).
2. In alignment with the CMS EQR Protocol 5 Validation of Encounter Data[1], HSAG has developed a proposal to conduct the EDV study for three evaluation activities designed to evaluate the completeness and accuracy of MDHHS' encounter data. The three activities (**Deliverables**) are as follows:
   - **Information systems review**—assessment of MDHHS' and/or MCEs' information systems and processes
   - **Administrative profile**—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness
   - **Medical record review**—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing MDHHS' electronic encounter data to the information documented in the corresponding members' medical records

To evaluate the completeness and accuracy of the Michigan Department of Health and Human Services' (MDHHS') encounter data, HSAG proposes conducting an Information Systems review and an Administrative Profile in state fiscal year (SFY) 2023 and a medical record review in SFY 2024 for each respective program. Combined, these activities will provide a detailed assessment of the relative completeness and accuracy of MDHHS' encounter data as well as insight into system-based factors that impact the quality of its encounter data.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Medicaid Managed Care Plan*. October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.htm

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **5**

to

Contract Number **190000001404**

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STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Courtney Powell	DTMB
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CONTRACT SUMMARY			
EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 AND NET 45		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-Card	☐ PRC	☐ Other	☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐		N/A
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$16,007,548.05	$349,248.00		$16,356,796.05	

DESCRIPTION

Effective July 19, 2022, Attachment 1 from Change Notice 3 is hereby deleted and replaced with the attached Attachment 1 - Revised. In addition, this Contract is increased by $349,248.00 to support the continued technical reporting of MI Choice External Quality Review. All other terms, conditions, specifications, and pricing remain the same. Per Contractor and Agency agreement, DTMB Central Procurement Services approval, and State Administrative Board approval on July 19, 2022.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Kimberly Hamilton	517-284-1147	HamiltonK@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

Health Services Advisory Group, Inc.

Michigan Department of Health and Human Services (MDHHS)

MI Choice External Review Technical Report (SFY 2021 and SFY 2022 Reports)

Project	Description	Assumptions	Proposed Cost for SFY 2020 Report (completed in CY 2021)	Proposed Cost for SFY 2021 Report (completed in CY 2022)	Proposed Cost for SFY 2022 Report (completed in CY 2023)
MI Choice External Quality Review (EQR)Technical Report	The MI Choice EQR Technical Report will adhere to the requirements outlined in 42 CFR § 438.364.	A comprehensive assessment will be completed of each of the 20 MI Choice PAHPs using data supplied by MDHHS and information extracted from the MDHHS website. Additionally, the report will include a comparison of the PAHPs and the overall performance of the MI Choice program related to the quality, access, and timeliness of services provided to waiver members. HSAG will also provide detailed and meaningful recommendations to MDHHS for improving the MI Choice program.	$164,377	$171,116	$178,132

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
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CONTRACT CHANGE NOTICE

Change Notice Number **4**

to

Contract Number **190000001404**

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STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Courtney Powell	DTMB
		(517) 249-0452	
		powellc11@michigan.gov	

CONTRACT SUMMARY			
EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 and Net 45		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-Card	☐ PRC	☐ Other	☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐	N/A	☐	N/A	N/A
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$15,629,964.05	$377,584.00		$16,007,548.05	

DESCRIPTION

Effective December 14, 2021, this Contract is increased by $377,584.00 to add services to Schedule B.1 Pricing for Michigan Department of Health and Human Services (MDHHS) use, per the attached Revised Schedule B.1 Pricing.

All other terms, conditions, specifications, and pricing remain the same. Per Contractor and Agency agreement, DTMB Central Procurement Services approval, and State Administrative Board approval on December 14, 2021.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Thomas Curtis	517-284-1152	CurtisT2@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

STATE OF MICHIGAN

Contract No. 190000001404
Change Notice 4
External Quality Review Organization (EQRO) and Customer Satisfaction Survey for the
Michigan Department of Health & Human Services (MDHHS)

REVISED SCHEDULE B.1
PRICING

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

2. **Quick payment terms**: 0.5 % discount off invoice if paid within 30 days after receipt of invoice.

3. The following is a breakdown of the Customer Assessment of Healthcare Providers and Systems (CAHPS) surveys and reports activities:

- **Adult Medicaid CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item sent to the adult Fee-for-Service (FFS) population only and reporting of Adult FFS and Medicaid health plans (MHPs) CAHPS Survey results. The 11 Health plans will submit their audited CAHPS 5.0 Survey data and this data will be analyzed by the contractor.

- **Child Medicaid CAHPS Survey** activities must include administration of the CAHPS 5.0 Child Medicaid Survey without the Children with Chronic Conditions (CCC) measurement set ("CAHPS 5.0 Child Medicaid Survey") to child Medicaid members enrolled in the FFS population and MHPs, as well as reporting of Child Medicaid FFS and MHP CAHPS Survey results.

- **CSHCS Survey** activities must include administration of the CSHCS Survey to CSHCS child members enrolled in the FFS population (Medicaid and non-Medicaid) and MHPs, including reporting of the survey results.

- **Adult ICO CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to adult members dually eligible for Medicare and Medicaid (i.e., dual eligible adult members) enrolled in the 7 ICO health plans participating in Michigan's Medicare-Medicaid Dual Eligible Demonstration project, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Adult ICO CAHPS HCBS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to members dually eligible for Medicare and Medicaid (i.e., dual eligible adult members) enrolled in the 7 ICO health plans participating in Michigan's Medicare-Medicaid Dual Eligible Demonstration project, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings. This report will include results from the survey done for the population which receives inhouse and community-based services.
https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

- **Adult HMP CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to adult members enrolled in the 11 HMP health plans participating in Michigan's Medicaid expansion program, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Adult HMP Dental CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Dental Survey with the HEDIS® supplemental item set to adult members enrolled in the 11 HMP health plans who administer dental benefits or subcontract with a dental contractor participating in Michigan's Medicaid expansion program, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Healthy Kids Dental CAHPS Survey** activities must include administration of the CAHPS 5.0 Dental Survey with the HEDIS® supplemental item sent to Healthy Kids Dental members enrolled in the 2 Dental

health plans as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings

Table 1:

CAHPS Survey Tasks	Population Size Estimate	Year One Pricing	Year Two Pricing	Year Three Pricing	Year four Pricing	Year five Pricing	Total five-Year Pricing for CAHPS Services
FFS – Adult Medicaid CAHPS Survey	288,179	$19,961.63	$20,760.91	$21,592.20	$22,456.47	$23,354.69	$108,125.90
FFS – Child Medicaid CAHPS Survey	158,814	$21,863.80	$22,738.74	$23,647.63	$24,594.35	$25,577.93	$118,422.45
MHP – Adult Medicaid Statewide Report	466,041	$5,228.30	$5,437.82	$5,655.10	$5,881.11	$6,115.85	$28,318.18
MHP – Child Medicaid CAHPS Surveys	775,176	$187,268.20	$194,758.54	$202,549.58	$210,651.02	$219,077.41	$1,014,304.75
FFS – CSHCS Survey	8,982	$35,172.20	$36,578.70	$38,042.43	$39,564.36	$41,146.43	$190,504.12
MHP – CSHCS Surveys	23,619	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
ICO – Adult CAHPS Surveys	37,743	$101,714.20	$0.00	$0.00	$0.00	$0.00	$101,714.20
ICO- Adult CAHPS HCBS surveys (receiving inhouse and community-based services)	12,000	$187,268.20	$194,758.54	$202,549.58	$210,651.02	$219,077.41	$1,014,304.75
HMP – Adults CAHPS Surveys	697,709	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
HMP- Adults Dental Plan CAHPS surveys	697,709	$144,491.20	$150,270.46	$156,281.55	$162,532.23	$169,034.14	$782,609.58
HKD – Child Dental Plan CAHPS surveys	969,196	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,386.59	$293,477.38
Total Five-Year Price							**$5,165,514.81**

Please calculate sample size based on the population size given in the table below.

*The actual population sizes can vary throughout the term of the contract.

The following is a breakdown of the EQRO Services for Michigan's Medicaid Managed Care Organizations:

PIP

1. The Contractor must provide MDHHS with an objective comprehensive of whether the MHP's, DHP's and ICO's PIP is methodologically sound.
2. The Contractor must develop a template and evaluate PIP for each MHP, DHP, ICO to assess the soundness and results of the PIP.
3. The Contractor must provide technical assistance to MDHHS and to ensure that the PIP projects are consistent with EQR protocol.

Technical Report

1. The Contractor must produce a detailed, a technical report that describes the data from all EQR related activities, which are aggregated and analyzed that summarize the quality, timeliness, and access to care furnished to MHP including HMP, a separate report for DHP and a separate report for ICO.
2. The Contractor must review annual MHP compliance review, validate performance measures results, validate network adequacy, evaluate MHP quality improvement projects, evaluate CAHPS survey results, and evaluate clinical and/or nonclinical focused studies conducted by EQRO during preceding year (at the State's discretion).

HEDIS and Other Performance Measures

1. The Contractor must utilize the most current National Committee for Quality Assurance (NCQA) Medicaid benchmarks to accurately evaluate and perform HEDIS analysis.
2. The Contractor must perform comprehensive review and analysis of contracted Michigan MHPs and IDSS results for each reporting year of this contract.
3. The Contractor must comparatively review MHP quality of care outcomes and performance measures and utilize the findings as part of this task for inclusion in EQR technical report.

Consumer Guide

1. The Contractor must utilize the results of HEDIS Analysis and CAHPS findings to perform statistical tests to compare MHP/DHP performance to Statewide means, benchmarks, and goals where appropriate, and conduct descriptive comparative analysis using NCQA benchmarks.
2. The Contractor must propose two methodologies to calculate MHP/DHP specific results for use in the Consumer Guide and/or Performance Bonus using Medicaid 50th percentile benchmark or Michigan Weighted Average (Aggregate Rate) as the reference point.
3. The Contractor must maintain the five categories addressed in the current Consumer Guide.

Table 2:

EQRO Tasks – MHP including HMP Dental	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$73,268.95	$76,200.29	$79,248.03	$82,417.99	$85,715.02	$396,850.28
Technical Report	$82,702.20	$86,009.90	$89,450.49	$93,028.82	$96,749.74	$447,941.15
HEDIS and Other Performance Measures	$120,726.20	$125,554.86	$130,577.52	$135,800.97	$141,232.97	$653,892.52
Consumer Guide	$33,271.00	$34,601.84	$35,986.03	$37,425.51	$38,922.22	$180,206.60
Network Adequacy with Secret shopper call	$0.00	$0.00	$190,987	$240,951.88	$250,599.80	$682,538.68
Total Five-Year Price						**$2,361,419.23**

EQRO Tasks - HKD	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$13,321.98	$13,855.48	$14,409.35	$14,985.53	$15,584.99	$72,157.33
Technical Report	$25,666.20	$26,692.46	$27,760.43	$28,871.08	$30,025.38	$139,015.55
HEDIS and Other Performance Measures	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
Consumer Guide	$25,666.20	$0.00	$30,000.00	$30,000.00	$30,000.00	$115,666.20
Network Adequacy and Secret Shopper Call	$0.00	$0.00	$96,597	$121,015.26	$125,858.47	$343,470.73
Total Five-Year Price						**$963,788.16**

EQRO Tasks - ICO	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$46,625.96	$48,491.27	$50,430.30	$52,447.90	$54,545.04	$252,540.47
Technical Report	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
HEDIS and Other Performance Measures Validation	$121,337.00	$126,190.48	$131,238.10	$136,487.62	$141,947.12	$657,200.32
Compliance Review	$110,233.71	$110,233.71	$110,233.71	$123,997.04	$123,997.04	$578,695.21
Network Adequacy and Secret Shopper Calls	$187,268.20	$205,995.02	$214,235.17	$222,804.15	$231,718.45	$1,062,020.99
Total Five-Year Price						**$2,843,935.34**

Total Five-Year Price from Table 1	$5,165,514.81
Total Five-Year Price from Table 2 (MHP, HKD, ICO)	$6,169,142.73
Total Five- Year Contract Price	**$11,334,657.54**

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 **3**

to

Contract Number **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Courtney Powell	DTMB
		(517) 249-0452	
		powellc11@michigan.gov	

CONTRACT SUMMARY			
EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-Card	☐ PRC	☐ Other	☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐		N/A
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$15,629,964.05	$0.00		$15,629,964.05	

DESCRIPTION

Effective June 25, 2021, MIChoice is hereby added to the technical reporting activities as described in the attached.

All other terms, conditions, specifciations and pricing remain the same. Per Contractor and Agency agreement, and DTMB Central Procurement Services approval.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Thomas Curtis	517-284-1152	CurtisT2@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

Health Services Advisory Group, Inc.
Michigan Department of Health and Human Services (MDHHS)
MI Choice External Quality Review Technical Report (SFY 2020 Report)

Project	Description	Assumptions	Proposed Cost
MI Choice External Quality Review (EQR)Technical Report	The MI Choice EQR Technical Report will adhere to the requirements outlined in 42 CFR § 438.364.	A comprehensive assessment will be completed of each of the 20 MI Choice PAHPs using data supplied by MDHHS and information extracted from the MDHHS website. Additionally, the report will include a comparison of the PAHPs and the overall performance of the MI Choice program related to the quality, access, and timeliness of services provided to waiver members. Contractor will also provide detailed and meaningful recommendations to MDHHS for improving the MI Choice program.	$ 164,377

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 **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	MDHHS
	Contract Administrator	Courtney Powell	DTMB
		(517) 249-0452	
		powellc11@michigan.gov	

CONTRACT SUMMARY			
EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-Card	☐ PRC	☐ Other	☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐	N/A	☐	N/A	N/A
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$15,629,964.05	$0.00		$15,629,964.05	

DESCRIPTION

Effective February 1, 2021, pricing on this Contract is decreased, per attachment Schedule B, Pricing.

All other terms, conditions, specifications and pricing remain the same. Per Contractor and Agency agreement, and DTMB Central Procurement Services approval.

Program Managers
for
Multi-Agency and Statewide Contracts

AGENCY	NAME	PHONE	EMAIL
MDHHS	Kathleen M. Haines	517-335-0179	HainesK@michigan.gov
MDHHS	Thomas Curtis	517-284-1152	CurtisT2@michigan.gov
MDHHS	Allison Repp	517-241-5781	ReppA@michigan.gov

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization (EQRO) and Customer Satisfaction Survey for the
Michigan Department of Health & Human Services (MDHHS)

SCHEDULE B.1
PRICING

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

2. **Quick payment terms**: 0.5 % discount off invoice if paid within 30 days after receipt of invoice.

3. The following is a breakdown of the Customer Assessment of Healthcare Providers and Systems (CAHPS) surveys and reports activities:

- **Adult Medicaid CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item sent to the adult Fee-for-Service (FFS) population only and reporting of Adult FFS and Medicaid health plans (MHPs) CAHPS Survey results. The 11 Health plans will submit their audited CAHPS 5.0 Survey data and this data will be analyzed by the contractor.

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- **CSHCS Survey** activities must include administration of the CSHCS Survey to CSHCS child members enrolled in the FFS population (Medicaid and non-Medicaid) and MHPs, including reporting of the survey results.

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- **Adult HMP CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to adult members enrolled in the 11 HMP health plans participating in Michigan's Medicaid expansion program, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

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- **Healthy Kids Dental CAHPS Survey** activities must include administration of the CAHPS 5.0 Dental Survey with the HEDIS® supplemental item sent to Healthy Kids Dental members enrolled in the 2 Dental

health plans as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings

Table 1:

CAHPS Survey Tasks	Population Size Estimate	Year One Pricing	Year Two Pricing	Year Three Pricing	Year four Pricing	Year five Pricing	Total five-Year Pricing for CAHPS Services
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FFS – CSHCS Survey	8,982	$35,172.20	$36,578.70	$38,042.43	$39,564.36	$41,146.43	$190,504.12
MHP – CSHCS Surveys	23,619	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
ICO – Adult CAHPS Surveys	37,743	$101,714.20	$0.00	$0.00	$0.00	$0.00	$101,714.20
ICO- Adult CAHPS HCBS surveys (receiving inhouse and community-based services)	12,000	$187,268.20	$194,758.54	$202,549.58	$210,651.02	$219,077.41	$1,014,304.75
HMP – Adults CAHPS Surveys	697,709	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
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HKD – Child Dental Plan CAHPS surveys	969,196	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,386.59	$293,477.38
Total Five-Year Price							**$5,165,514.81**

Please calculate sample size based on the population size given in the table below.

*The actual population sizes can vary throughout the term of the contract.

The following is a breakdown of the EQRO Services for Michigan's Medicaid Managed Care Organizations:

PIP

1. The Contractor must provide MDHHS with an objective comprehensive of whether the MHP's, DHP's and ICO's PIP is methodologically sound.
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3. The Contractor must provide technical assistance to MDHHS and to ensure that the PIP projects are consistent with EQR protocol.

Technical Report

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2. The Contractor must review annual MHP compliance review, validate performance measures results, validate network adequacy, evaluate MHP quality improvement projects, evaluate CAHPS survey results, and evaluate clinical and/or nonclinical focused studies conducted by EQRO during preceding year (at the State's discretion).

HEDIS and Other Performance Measures

1. The Contractor must utilize the most current National Committee for Quality Assurance (NCQA) Medicaid benchmarks to accurately evaluate and perform HEDIS analysis.
2. The Contractor must perform comprehensive review and analysis of contracted Michigan MHPs and IDSS results for each reporting year of this contract.
3. The Contractor must comparatively review MHP quality of care outcomes and performance measures and utilize the findings as part of this task for inclusion in EQR technical report.

Consumer Guide

1. The Contractor must utilize the results of HEDIS Analysis and CAHPS findings to perform statistical tests to compare MHP/DHP performance to Statewide means, benchmarks, and goals where appropriate, and conduct descriptive comparative analysis using NCQA benchmarks.
2. The Contractor must propose two methodologies to calculate MHP/DHP specific results for use in the Consumer Guide and/or Performance Bonus using Medicaid 50th percentile benchmark or Michigan Weighted Average (Aggregate Rate) as the reference point.
3. The Contractor must maintain the five categories addressed in the current Consumer Guide.

Table 2:

EQRO Tasks – MHP including HMP Dental	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$73,268.95	$76,200.29	$79,248.03	$82,417.99	$85,715.02	$396,850.28
Technical Report	$82,702.20	$86,009.90	$89,450.49	$93,028.82	$96,749.74	$447,941.15
HEDIS and Other Performance Measures	$120,726.20	$125,554.86	$130,577.52	$135,800.97	$141,232.97	$653,892.52
Consumer Guide	$33,271.00	$34,601.84	$35,986.03	$37,425.51	$38,922.22	$180,206.60
Network Adequacy with Secret shopper call	$0.00	$0.00	$0.00	$240,951.88	$250,589.80	$491,541.68
Total Five-Year Price						**$2,170,432.23**

EQRO Tasks - HKD	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$13,321.98	$13,855.48	$14,409.35	$14,985.53	$15,584.99	$72,157.33
Technical Report	$25,666.20	$26,692.46	$27,760.43	$28,871.08	$30,025.38	$139,015.55
HEDIS and Other Performance Measures	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
Consumer Guide	$25,666.20	$0.00	$0.00	$0.00	$0.00	$25,666.20
Network Adequacy and Secret Shopper Call	$0.00	$0.00	$0.00	$121,015.26	$125,858.47	$246,873.73
Total Five-Year Price						**$777,191.16**

EQRO Tasks - ICO	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$46,625.96	$48,491.27	$50,430.30	$52,447.90	$54,545.04	$252,540.47
Technical Report	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
HEDIS and Other Performance Measures Validation	$121,337.00	$126,190.48	$131,238.10	$136,487.62	$141,947.12	$657,200.32
Compliance Review	$110,233.71	$110,233.71	$110,233.71	$123,997.04	$123,997.04	$578,695.21
Network Adequacy and Secret Shopper Calls	$187,268.20	$205,995.02	$214,235.17	$222,804.15	$231,718.45	$1,062,020.99
Total Five-Year Price						**$2,843,935.34**

Total Five-Year Price from Table 1	$5,165,514.81
Total Five-Year Price from Table 2 (MHP, HKD, ICO)	$5,791,558.73
Total Five- Year Contract Price	**$10,957,073.54**

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization Services for Prepaid Inpatient Health Plans – Michigan Department of Health and Human Services

SCHEDULE B.2
PRICING

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

2. **Quick payment terms**: 0.5 % discount off invoice if paid within 30 days after receipt of invoice.

3. The price list below is the Contractor's firm pricing for the duration of this Contract:

Annual Task Title	# Units	Total Price
Validation of Performance Improvement Projects	10 PIHPs	$72,155.39
Review of Compliance with Medicaid Managed Care Proposed Regulations	10 PIHPs	$227,229.29
Validation of Performance Indicators	10 PIHPs	$130,736.60
Validation and Implementation of Surveys	10 PIHPs	$248,643.50
Total Annual Contract Price		**$678,764.78**
Total 5 Year Contract Price		**$3,393,823.90**

* MDHHS currently contracts with 10 PIHPs, however with the Section 298 Project may require an additional PIHP.

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

REVISED CONTRACT CHANGE NOTICE

Revised Change Notice Number **1**

to

Contract Number **190000001404**

CONTRACTOR	
	HEALTH SERVICES ADVISORY GROUP, INC
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various	DTMB
	Contract Administrator	Courtney Powell	DTMB
		(517) 249-0452	
		powellc11@michigan.gov	

CONTRACT SUMMARY

EXTERNAL QUALITY REVIEW ORGANIZATION SERVICES AND CUSTOMER SATISFACTION SURVEY FOR MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
October 1, 2019	September 30, 2024	3 - 1 Year	September 30, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ PRC	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐	N/A	☐	N/A	N/A

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$15,629,964.05	$0.00	$15,629,964.05

DESCRIPTION

Effective August 28, 2020, the Contractor will provide Michigan Department of Health and Human Services (MDHHS) staff training to perform Technical Assistance for Medicaid Managed Care Program Monitoring Activities in Schedule A.2. The Contractor will provide MDHHS with the tools and technical assistance to effectively monitor key aspects of the Medicaid managed care behavioral health program in Michigan. Key areas of technical assistance will relate to the following program areas: Appeal and Grievance Systems; Utilization Management; Quality Assessment and Performance Improvement; and Provider Credentialing. Activity will include the following components: toolkit development; data request development; and ongoing training and technical assistance to MDHHS and the PIHPs.

All other terms, conditions, specifications and pricing remain the same. Per Contractor and Agency agreement, and DTMB Central Procurement Services approval.

STATE OF MICHIGAN PROCUREMENT

Department of Technology, Management and Budget
525 W. Allegan St., Lansing, MI 4893
P.O. Box 30026 Lansing, MI 48909

NOTICE OF CONTRACT

NOTICE OF CONTRACT NO. **190000001404**
between
THE STATE OF MICHIGAN
and

CONTRACTOR	
	Health Services Advisory Group, Inc
	3133 East Camelback Road, Suite 100
	Phoenix, AZ 85016
	Mary Ellen Dalton
	602-801-6701
	mdalton@hsag.com
	CV0065435

STATE			
	Program Manager	Various – See next page for Program Managers	DTMB
	Contract Administrator	Courtney Powell	DTMB
		517-249-0452	
		Powellc11@michigan.gov	

CONTRACT SUMMARY			
DESCRIPTION: External Quality Review Organization Services and Customer Satisfaction Survey for Michigan Department of Health and Human Services (MDHHS)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW**
10/1/2019	9/30/2024	3 – 1 Year	9/30/2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
.05NET30 and Net 45		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-card ☐ Payment Request (PRC) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			
MISCELLANEOUS INFORMATION			
THIS IS NOT AN ORDER: This Contract Agreement is awarded on the bases of our inquiry bearing the solicitation #190000001371. Orders for delivery will be issued through a Delivery Order.			
ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION			**$15,629,964.05**

Program Managers
for
Multi-Agency & Statewide Contracts

	AGENCY	NAME	PHONE	EMAIL
1	MDHHS	Kathleen Haines	517-335-0179	hainesk@michigan.gov
2	MDHHS	Tom Curtis	517-284-1152	curtist2@michigan.gov

FOR THE CONTRACTOR:

Health Services Advisory Group, Inc

Company Name

Authorized Agent Signature

Authorized Agent (Print or Type)

Date

FOR THE STATE:

Signature

Pamela Platte, Category Director
Name & Title

DTMB Procurement
Agency

Date

STATE OF MICHIGAN

STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and Health Services Advisory Group, Inc ("**Contractor**"), a Arizona corporation. This Contract is effective on October 1, 2019 ("**Effective Date**"), and unless terminated, expires on September 30, 2024.

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

The parties agree as follows:

1. **Duties of Contractor.** Contractor must perform the services and provide the deliverables described in **Schedule A.1 and A.2 – Statement of Work** (the "**Contract Activities**"). An obligation to provide delivery of any commodity is considered a service and is a Contract Activity.

   Contractor must furnish all labor, equipment, materials, and supplies necessary for the performance of the Contract Activities, and meet operational standards, unless otherwise specified in Schedule A.1 and A.2.

   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:
Courtney Powell 525 W. Allegan St Lansing, MI 48933	Mary Ellen Dalton 3133 E. Camelback Road, Suite 100 Phoenix, AZ 85016

powellc11@michigan.gov 517-249-0452	mdalton@hsag.com 602-801-6701

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

State:	Contractor:
Courtney Powell 525 W. Allegan St Lansing, MI 48933 powellc11@michigan.gov 517-249-0452	Mary Ellen Dalton 3133 E. Camelback Road, Suite 100 Phoenix, AZ 85016 mdalton@hsag.com 602-801-6701

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**"):

State:	Contractor:
Tom Curtis Michigan Department of Health and Human Services Capitol Commons Center 400 South Pine Lansing, MI 48933 Curtist2@michigan.gov Phone (517) 284-1152 and Kathleen Haines Michigan Department of Health and Human Services 320 South Walnut Lansing, MI 48913 HainesK@michigan.gov (517) 335-0179	Lee Ann Dougherty3133 E. Camelback Road, Suite 100 Phoenix, AZ 85016 LDougherty@hsag.com 614-360-2746

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

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

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum 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 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.

Umbrella or Excess Liability Insurance	
Minimum Limits: $5,000,000 General Aggregate	Contractor must have their policy follow form.
Automobile Liability Insurance	
Minimum Limits: $1,000,000 Per Accident	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 Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease	

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

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

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

Contractor must: (a) provide insurance certificates to the Contract Administrator, containing the agreement or delivery 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.

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

7. **Reserved.**

8. **Reserved.**

9. **Independent Contractor.** Contractor is an independent contractor and assumes all rights, obligations and liabilities set forth in this Contract. Contractor, its employees, and agents will not be considered employees of the State. No partnership or joint venture relationship is created by virtue of this Contract. Contractor, and not the State, is responsible for the payment of wages, benefits and taxes of Contractor's employees and any subcontractors. Prior performance does not modify Contractor's status as an independent contractor. Contractor hereby acknowledges that the State is and will be the sole and exclusive owner of all right, title, and interest in the Contract Activities and all associated intellectual property rights, if any. Such Contract Activities are works made for hire as defined in Section 101 of the Copyright Act of 1976. To the extent any Contract Activities and related intellectual property do not qualify as works made for hire under the Copyright Act, Contractor will, and hereby does, immediately on its creation, assign, transfer and otherwise convey to the State, irrevocably and in perpetuity, throughout the universe, all right, title and interest in and to the Contract Activities, including all intellectual property rights therein.

10. **Subcontracting.** Contractor may not delegate any of its obligations under the Contract without the prior written approval of the State. Contractor must notify the State at least 90 calendar days before the proposed delegation and provide the State any information it requests to determine whether the delegation is in its best interest. If approved, Contractor must: (a) be the sole point of contact regarding all contractual matters, including payment and charges for all Contract Activities; (b) make all payments to the subcontractor; and (c) incorporate the terms and conditions contained in this Contract in any subcontract with a subcontractor. Contractor remains responsible for the completion of the Contract Activities, compliance with the terms of this Contract, and the acts and omissions of the subcontractor. The State, in its sole discretion, may require the replacement of any subcontractor.

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

12. **Background Checks.** Pursuant to Michigan law, all agencies subject to IRS Pub. 1075 are required to ask the Michigan State Police to perform fingerprint background checks on all employees, including Contractor and Subcontractor employees, who may have access to any database of information maintained by the federal government that contains confidential or personal information, including, but not limited to, federal tax information. Further, pursuant to Michigan law, any agency described above is prohibited from providing Contractors or Subcontractors with the result of such background check. For more information, please see Michigan Public Act 427 of 2018. Upon request, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

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

14. **Change of Control.** Contractor will notify within 30 days of any public announcement or otherwise once legally permitted to do so, the State of a change in Contractor's organizational structure or ownership. For purposes of this Contract, a change in control means any of the following: (a) a sale of more than 50% of Contractor's stock; (b) a sale of substantially all of Contractor's assets; (c) a change in a majority of Contractor's board members; (d) consummation of a merger or consolidation of Contractor with any other entity; (e) a change in ownership through a transaction or series of transactions; (f) or the board (or the stockholders) approves a plan of complete liquidation. A change of control does not include any consolidation or merger effected exclusively to change the domicile of Contractor, or any transaction or series of transactions principally for bona fide equity financing purposes.

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

15. **Ordering.** Contractor is not authorized to begin performance until receipt of authorization as identified in Schedule A.

16. **Acceptance.** Contract Activities are subject to inspection and testing by the State within 30 calendar days of the State's receipt of them ("**State Review Period**"), unless otherwise provided in Schedule A. If the Contract Activities are not fully accepted by the State, the State will notify Contractor by the end of the State Review Period that either: (a) the Contract Activities are accepted, but noted deficiencies must be corrected; or (b) the Contract Activities are rejected. If the State finds material deficiencies, it may: (i) reject the Contract Activities without performing any further inspections; (ii) demand performance at no additional cost; or (iii) terminate this Contract in accordance with Section 2222, 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.**

Terms of Payment. Invoices must conform to the requirements communicated from time-to-time by the State. All undisputed amounts are payable within 45 days of the State's receipt. Contractor may only charge for Contract Activities performed as specified in Schedule A. Invoices must include an itemized statement of all charges. The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use. All prices are exclusive of taxes, and Contractor is responsible for all sales, use and excise taxes, and any other similar taxes, duties and charges of any kind imposed by any federal, state, or local governmental entity on any amounts payable by the State under this Contract.

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

The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor

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must register with the State at http://www.michigan.gov/SIGMAVSS 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.

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

21. **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 delivery order. The State will not pay for Contract Activities, Contractor's lost profits, or any additional compensation during a stop work period.

22. **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.

23. **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 2424, 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.

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24. **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 180 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.

25. **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.

26. **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.

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

28. **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.

29. **Reserved.**

30. **State Data.**

a. Ownership. The State's data ("**State Data**," which will be treated by Contractor as Confidential Information) includes: (a) the State's data collected, used, processed, stored, or generated as the result of the Contract Activities; (b) personally identifiable information ("**PII**") collected, used, processed, stored, or generated as the result of the Contract Activities, including, without limitation, any information that identifies an individual, such as an individual's social security number or other government-issued identification number, date of birth, address, telephone number, biometric data, mother's maiden name, email address, credit card information, or an individual's name in combination with any other of the elements here listed; and, (c) personal health information ("**PHI**") collected, used, processed, stored, or generated as the result of the Contract Activities, which is defined under the Health Insurance Portability and Accountability Act (HIPAA) and its related rules and regulations. State Data is and will remain the sole and exclusive property of the State and all right, title, and interest in the same is reserved by the State. This Section survives the termination of this Contract.

b. Contractor Use of State Data. Contractor is provided a limited license to State Data for the sole and exclusive purpose of providing the Contract Activities, including a license to collect, process, store, generate, and display State Data only to the extent necessary in the provision of the Contract Activities. Contractor must: (a) keep and maintain State Data in strict confidence, using such degree of care as is appropriate and consistent with its obligations as further described in this Contract and applicable law to avoid unauthorized access, use, disclosure, or loss; (b) use and disclose State Data solely and exclusively for the purpose of providing the Contract Activities, such use and disclosure being in accordance with this Contract, any applicable Statement of Work, and applicable law; and (c) not use, sell, rent, transfer, distribute, or otherwise disclose or make available State Data for Contractor's own purposes or for the benefit of anyone other than the State without the State's prior written consent. This Section survives the termination of this Contract.

c. Extraction of State Data. Contractor must, within five (5) business days of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to Contractor), an extract of the State Data in the format specified by the State.

d. Backup and Recovery of State Data. Unless otherwise specified in Schedule 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 Schedule A, Contractor must maintain a contemporaneous backup of State Data that can be recovered within two (2) hours at any point in time.

e. Loss or Compromise of Data. In the event of any act, error or omission, negligence, misconduct, or breach on the part of Contractor that compromises or is suspected to compromise the security, confidentiality, or integrity of State Data or the physical, technical, administrative, or organizational safeguards put in place by Contractor that relate to the protection of the security, confidentiality, or integrity of State Data, Contractor must, as applicable: (a) notify the State as soon as practicable but no later than twenty-four (24) hours of becoming aware of such occurrence; (b) cooperate with the State in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the State; (c) in the case of PII or PHI, at the State's sole election, (i) with approval and assistance from the State, 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 (5) calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for no less than twenty-four (24) months following the date of notification to such individuals; (e) perform or take any other actions required to comply with applicable law as a result of the occurrence; (f) pay for any costs associated with the occurrence, including but not limited to any costs incurred by the State in investigating and resolving the occurrence, including reasonable attorney's fees associated with such investigation and resolution; (g) 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 incidental expenses, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (h) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and (i) provide to the State a detailed plan within ten (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, not be tangentially used for any solicitation purposes, 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. The State will have the option to review and approve any notification sent to affected individuals prior to its delivery. Notification to any other party, including but not limited to public media outlets, must be reviewed and approved by the State in writing prior to its dissemination. The parties agree that any damages relating to a breach of this **Section 30** are to be considered direct damages and not consequential damages. This section survives termination or expiration of this Contract.

f. State's Governance, Risk and Compliance (GRC) platform. Contractor is required to assist the State with its security accreditation process through the development, completion and ongoing updating of a system security plan using the State's automated GRC platform, and implement any required safeguards or remediate any security vulnerabilities as identified by the results of the security accreditation process.

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

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

b. Obligation of Confidentiality. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or subcontractors of a party who have a need to know in connection with this Contract or to use such Confidential Information for any purposes whatsoever other than the performance of this Contract. The parties agree to advise and require their respective employees, agents, and subcontractors of their obligations to keep all Confidential Information confidential. Disclosure to a subcontractor is permissible where: (a) use of a subcontractor is authorized under this Contract; (b) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the subcontractor's responsibilities; and (c) Contractor obligates the subcontractor in a written contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor or any subcontractor may be required to execute a separate agreement to be bound by the provisions of this Section.

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

d. Remedies for Breach of Obligation of Confidentiality. Each party acknowledges that breach of its obligation of confidentiality may give rise to irreparable injury to the other party, which damage may be inadequately compensable in the form of monetary damages. Accordingly, a party may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies which may be available, to include, in the case of the State, at the sole election of

the State, the immediate termination, without liability to the State, of this Contract or any Statement of Work corresponding to the breach or threatened breach.

e. Surrender of Confidential Information upon Termination. Upon termination of this Contract or a Statement of Work, in whole or in part, each party must, within 5 calendar days from the date of termination, return to the other party any and all Confidential Information received from the other party, or created or received by a party on behalf of the other party, which are in such party's possession, custody, or control; provided, however, that Contractor must return State Data to the State following the timeframe and procedure described further in this Contract. Should Contractor or the State determine that the return of any Confidential Information is not feasible, such party must destroy the Confidential Information and must certify the same in writing within 5 calendar days from the date of termination to the other party. However, the State's legal ability to destroy Contractor data may be restricted by its retention and disposal schedule, in which case Contractor's Confidential Information will be destroyed after the retention period expires.

32. 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.

33. Reserved.

34. Reserved.

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

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

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

36. **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;(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; and that (i) Contractor is neither currently engaged in nor will engage in the boycott of a person based in or doing business with a strategic partner as described in 22 USC 8601 to 8606. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 22, Termination for Cause.

37. **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.

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

39. **Reserved.**

40. **Reserved.**

41. **Nondiscrimination.** Under the Elliott-Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, *et seq*., the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, *et seq*., and Executive Directive 2019-09. Contractor and its subcontractors agree not to discriminate against an employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex (as defined in Executive Directive 2019-09), height, weight, marital status, partisan considerations, any mental or physical disability, or genetic information that is unrelated to the person's ability to perform the duties of a particular job or position. Breach of this covenant is a material breach of this Contract.

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 compiled 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.
    (i)

49. **Schedules**. All Schedules and Exhibits that are referenced herein and attached hereto are hereby incorporated by reference. The following Schedules are attached hereto and incorporated herein:

Schedule A.1	Statement of Work
Schedule A.2	Statement of Work
Schedule B.1	Pricing Matrix for A.1 scope
Schedule B.2	Pricing Matrix for A.2 scope
Schedule C	HIPAA - Business Associates Agreement

50. **Entire Agreement and Order of Precedence.** This Contract, which includes Schedule A – Statement of Work, and schedules and exhibits which are hereby expressly incorporated, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, this Contract, excluding its schedules, exhibits, and Schedule A – Statement of Work; (b) second, Schedule A – Statement of Work as of the Effective Date; and (c) third, schedules

expressly incorporated into this Contract as of the Effective Date. NO TERMS ON CONTRACTOR'S INVOICES, ORDERING DOCUMENTS, WEBSITE, BROWSE-WRAP, SHRINK-WRAP, CLICK-WRAP, CLICK-THROUGH OR OTHER NON-NEGOTIATED TERMS AND CONDITIONS PROVIDED WITH ANY OF THE CONTRACT ACTIVITIES WILL CONSTITUTE A PART OR AMENDMENT OF THIS CONTRACT OR IS BINDING ON THE STATE FOR ANY PURPOSE. ALL SUCH OTHER TERMS AND CONDITIONS HAVE NO FORCE AND EFFECT AND ARE DEEMED REJECTED BY THE STATE, EVEN IF ACCESS TO OR USE OF THE CONTRACT ACTIVITIES REQUIRES AFFIRMATIVE ACCEPTANCE OF SUCH TERMS AND CONDITIONS.

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

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

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

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

Federal Provisions Addendum

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

1. **Federally Assisted Construction Contracts.** If this contract is a "**federally assisted construction contract**" as defined in 41 CRF Part 60-1.3, and except as otherwise may be provided under 41 CRF Part 60, then during performance of this Contract, the Contractor agrees as follows:

   (1) The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following:

   Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

   (2) The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

   (3) The Contractor will not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This provision shall not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.

   (4) The Contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the Contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

   (5) The Contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(6) The Contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(7) In the event of the Contractor's noncompliance with the nondiscrimination clauses of this contract or with any of the said rules, regulations, or orders, this Contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(8) The Contractor will include the portion of the sentence immediately preceding paragraph (1) and the provisions of paragraphs (1) through (8) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to section 204 of Executive Order 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance:

Provided, however, that in the event a Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the administering agency, the Contractor may request the United States to enter into such litigation to protect the interests of the United States.

2. Davis-Bacon Act (Prevailing Wage)
(ii)

a. If applicable, the Contractor (and its Subcontractors) for **prime construction contracts** in excess of $2,000 must comply with the Davis-Bacon Act (40 USC 3141-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction").

b. The Contractor (and its Subcontractors) shall pay all mechanics and laborers employed directly on the site of the work, unconditionally and at least once a week, and without subsequent deduction or rebate on any account, the full amounts accrued at time of payment, computed at wage rates not less than those stated in the advertised specifications, regardless of any contractual relationship which may be alleged to exist between the Contractor or subcontractor and the laborers and mechanics;

c. The Contractor will post the scale of wages to be paid in a prominent and easily accessible place at the site of the work;

d. There may be withheld from the Contractor so much of accrued payments as the contracting officer considers necessary to pay to laborers and mechanics employed by the Contractor or any Subcontractor on the work the difference between the rates of wages required by the Contract to be paid laborers and mechanics on the work and the rates of wages received by the laborers and mechanics and not refunded to the Contractor or Subcontractors or their agents.

3. Copeland "Anti-Kickback" Act. If applicable, the Contractor must comply with the Copeland "Anti-Kickback" Act (40 USC 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the

United States"), which prohibits the Contractor and subrecipients from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled.

4. **Contract Work Hours and Safety Standards Act.** If the Contract is **in excess of $100,000** and **involves the employment of mechanics or laborers**, the Contractor must comply with 40 USC 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

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

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

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

8. **Byrd Anti-Lobbying Amendment.** If this Contract **exceeds $100,000**, bidders and the Contractor must file the certification required under 31 USC 1352.

9. **Procurement of Recovered Materials.** Under 2 CFR 200.322, a non-Federal entity that is a state agency or agency of a political subdivision of a state **and its contractors** must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

Byrd Anti-Lobbying Certification

The following certification and disclosure regarding payments to influence certain federal transactions are made under FAR 52.203-11 and 52.203-12 and 31 USC 1352, the "Byrd Anti-Lobbying Amendment." Hyperlinks are provided for convenience only; broken hyperlinks will not relieve Contractor from compliance with the law.

1. FAR 52.203-12, "Limitation on Payments to Influence Certain Federal Transactions" is hereby incorporated by reference into this certification.

2. The bidder, by submitting its proposal, hereby certifies to the best of his or her knowledge and belief that:

    a. No federal **appropriated** funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress on his or her behalf in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement;

    b. If any funds **other than federal appropriated funds** (including profit or fee received under a covered federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress on his or her behalf **in connection with this solicitation**, the bidder must complete and submit, with its proposal, OMB standard form LLL, Disclosure of Lobbying Activities, to the Solicitation Manager; and

    c. He or she will include the language of this certification in all subcontract awards at any tier and require that all recipients of subcontract awards in excess of $150,000 must certify and disclose accordingly.

3. This certification is a material representation of fact upon which reliance is placed at the time of Contract award. Submission of this certification and disclosure is a prerequisite for making or entering into this Contract under 31 USC 1352. Any person making an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision is subject to a civil penalty of not less than $10,000, and not more than $100,000, for each such failure.

Signed by:

_____

Mary Ellen Dalton, President and Chief Executive Officer

Health Services Advisory Group, Inc

Date: _____

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization (EQRO) and Customer Satisfaction Survey for the Michigan Department of Health & Human Services (MDHHS)

SCHEDULE A.1
STATEMENT OF WORK
CONTRACT ACTIVITIES

BACKGROUND

This is a contract for an External Quality Review Organization (EQRO), to perform independent external quality review (EQR) services that consist of mandatory and optional activities as specified in the 42 C.F.R. § 438.358 and § 422. 153. External Quality Review services are for Medicaid Health Plans (MHPs) which are contracted for Medicaid, Dental Health Plans (DHP) and Integrated Care Organizations (ICO) that are contracted with the Michigan Department of Health and Human Services (MDHHS) for managed care services for the Medicaid, Healthy Michigan, Healthy Kids Dental and MI Health Link programs.

This is a contract for EQRO Services for Michigan's Medicaid Managed Care Organizations. The Contractor must provide services to complete an External Quality Review (EQR) of Michigan's Medicaid Managed Care Organizations in accordance with the Center for Medicaid and Medicare Services (CMS). The Contractor must conduct and report Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for MDHHS. The CAHPS® survey activity consist of the following populations: Adult Medicaid, Child Medicaid, Children's Special Health Care Services (CSHCS), Adult populations under Integrated Care Organization (ICO), Healthy Michigan Plan (HMP) and Healthy Kids Dental (HKD) and Healthy Michigan Plan Dental (HMPD).

Additional EQRO and CAHPS Services
As part of the MDHHS annual reporting requirements, the Contractor must conduct and report a comprehensive Healthcare Effectiveness Data & Information Set (HEDIS®) analysis of the contracted Health Plans (MHPs). MDHHS requires additional EQRO and CAHPS services for other MDHHS programs such as HKD and HMPD and ICO. As such needs arise, MDHHS may request a quote/proposal from the Contractor and, if quote/proposal is acceptable, MDHHS will incorporate the statement of work into the Contract through the formal contract change notice process. This provision does not preclude MDHHS from issuing a formal bid and awarding a separate contract(s) for the additional EQRO services.

Medicaid Program Background
Beginning in January 1974, the State first offered beneficiaries the option of receiving their health care from a health maintenance organization.

Since 1997, MDHHS began the implementation of its value-based purchasing initiative of managed care known as the Comprehensive Health Care Program (CHCP). The CHCP was designed to enroll Medicaid beneficiaries into competitively bid full risk/shared risk capitated arrangements. MDHHS is required to conduct annual adult satisfaction surveys since 1999 and has conducted child satisfaction surveys every other year since 1999.

CHCP program includes the expanded Medicaid HMP population for physical health needs and includes the HMPD population for the dental benefits. The Contract requires that all MHPs conduct annual satisfaction surveys of their adult enrollee population. Additionally, as a result of the following factors, MHPs are required to conduct annual surveys:

1. Applicable CMS waiver requirements for some Medicaid programs;
2. Program management and oversight; and/or
3. Legislative oversight requirements.

Current MHPs must hold and maintain accreditation as a managed care organization with the National

Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC). To seek and maintain NCQA accreditation, health plans must collect and report current audited CAHPS® Adult Survey results annually.

In addition to accreditation information and HEDIS® measures, selected CAHPS® measures are an integral part of the annual Michigan Medicaid Managed Care Consumer Guide.

https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf

The Guide is provided to all new Medicaid enrollees and supports the Department's initiatives to provide consumers, as well as policy makers and other stakeholders, with information about the quality of care and service provided to Medicaid managed care enrollees. Selected CAHPS® measures are also a part of the MDHHS annual MHP Performance Bonus Award.

Integrated Care Organization (ICO) - MI Health Link Program Background:
The MI Health Link Program was developed in response to the Centers for Medicare and Medicaid Services (CMS) Financial Alignment Initiative (FAI) opportunity. With goals to align financing of Medicare and Medicaid programs, as well as to integrate primary, acute, behavioral health, and long-term services and supports for individuals eligible for both programs, Michigan received approval and initial grant funding to create and implement MI Health Link. MI Health Link offers integrated service delivery for all covered Medicare and Medicaid services, including care coordintion, for beneficiaries 21 years of age or older, who reside in one of four geographical regions throughout the State. MI Health Link is governed by a three-way contractual agreement between CMS, MDHHS, and the Integrated Care Organization (ICOs or Heath Plans) selected to deliver services to program enrollees. As per the MHL three-way agreement and the Code of Federal Regulations, program EQRO activities are required.

Beneficiaries will be surveyed using the Adult CAHPS® and Adult Home and Community-based Services (HCBS) CAHPS® Surveys. MDHHS reserves the right to modify survey questions as allowable by NCQA.

Healthy Kids Dental Program (HKD) Background:
The HKD program is a PAHP and is for all covered Medicaid beneficiaries 21 years of age and under, who reside throughout the State of MI and enrolled in any of the 2 DHPs. The 2 DHPs started a new contract as of October 1, 2018.

Children's Special Health Care Services (CSHCS) Background
The Michigan Crippled Children Program was initiated by the State Legislature in 1927, with the Michigan Crippled Children Commission named as the official State agency for the program. The powers and duties of the Crippled Children Commission were expanded with the passage of Act 158 of the Public Acts of 1937. The Commission was transferred to the Michigan Department of Public Health in 1965 and is currently governed by Part 58, Act 368 of the Public Acts of 1978 (known as the Public Health Code). The name of the program was officially changed to Children's Special Health Care Services (CSHCS) in 1988.

The State, through the CSHCS program, provides access to specialty medical care for children and certain adults who meet specific medical eligibility criteria and require the care of pediatric or adult subspecialty physicians. The program's mission has been to locate children with special health care needs, provide appropriate treatment services, and to the extent possible, prevent "crippling conditions." Optimum, long-term health outcomes for children with special health care needs are central to the program's mission, as defined by State legislation. The CSHCS program is also known as the Title V program.

Medicaid provides preventive and primary healthcare, and CSHCS provides specialty care services for the CSHCS qualifying diagnosis. CSHCS enrollees who do not qualify for Medicaid are eligible only for specialty health care services related to their qualifying diagnosis under the CSHCS program. Medicaid and CSHCS also provide certain other services such as transportation when children meet specific criteria.

As a result of the following factors, the State is required to conduct satisfaction surveys of beneficiaries every year enrolled in CSHCS:

1. Applicable CMS waiver requirements,

2. Program management and oversight, and/or
3. Legislative oversight requirements.

Beneficiaries will be surveyed using the HEDIS®/CAHPS® Child Survey. MDHHS reserves the right to modify survey questions as allowable by NCQA. This includes, but not limited to a CAHPS® Survey for CSHCS beneficiaries eligible for HKD.

Contract Goals

There are two main goals for Schedule A.1 of this Contract:1) to perform external quality review activities (mandatory and optional) and produce associated deliverables to assure Michigan's Medicaid's compliance with CMS requirements; and 2) to provide the health plans with technical assistance and national expertise to efficiently and effectively administer the Medicaid managed care programs.

SCOPE

The primary scope of Schedule A.1 of this Contract is to provide Performance Improvement Project (PIP) validation and technical assistance; Performance Measure Validation; Review of Compliance with Access, Structural; and Operational Standards, and Network Adequacy Validation. Additionally, the Contractor must conduct consumer satisfaction surveys of the following populations: Adult and Child Medicaid, CSHCS, ICO, HMP, HMP Dental and HKD to ensure enrollees are receiving appropriate services in the MDHHS health care programs.

Please see Table 1 for the activities requested in this proposal by Plan and Program types.

Table 1: Michigan Medicaid External Quality Review Organization Request for Proposals: Program Type and Activities Matrix

	EQR Activity Required in this Contract					
Plan/Program Type	**PIP Validation and technical assistance**	**Performance Measure Validation (analysis of HEDIS, other data sources)**	**Review of Compliance with Access, Structural, and Operations Standards**	**Network Adequacy Validation including Secret Shopper call**	**CAHPS**	**Consumer Guide**
Medicaid Health Plan (MHP): Adult	X	X	X	X	X*	X
Medicaid Health Plan (MHP): Child					X*	
Medicaid Health Plan (MHP): CSHCS					X*	
Medicaid Health Plan (MHP): Healthy Michigan (Physical Health)					X	
Medicaid Health Plan (MHP): Healthy Michigan (Dental Benefits)					X	
Fee-for-Service: Adult					X	
Fee-for-Service: Child					X	
Fee-for-Service: CSHCS					X	
Integrated Care Organizations (ICOs)	X	X	X	X	X	
Dental Health Plans/PAHPs	X	X	X	X	X	X

*CAHPS survey: Some CAHPS surveys are administered by Medicaid Health Plans Contractor and the EQRO contractor will receive all necessary data directly from MHP. In other instances, MDHHS will send some sample files to perform required activities and complete required deliverables.

Current Medicaid Health Plans (11):

1. Aetna Better Health of Michigan – Contract No. 071B6600026
   https://www.michigan.gov/documents/micontractconnect/6600026_510234_7.pdf
2. Blue Cross Complete of Michigan – Contract No. 190000000411
   https://www.michigan.gov/documents/micontractconnect/6600024_510098_7.pdf
3. HAP Empowered – Contract No. 071B6600033
   https://www.michigan.gov/documents/micontractconnect/6600033_510108_7.pdf
4. Trusted Health plan Michigan Inc – Contract No. 071B6600032
   https://www.michigan.gov/documents/micontractconnect/6600032_510106_7.pdf
5. Meridian Health Plan – Contract No. 071B6600028
   https://www.michigan.gov/documents/micontractconnect/6600028_510101_7.pdf
6. McLaren Health Plan – Contract No. 071B6600029
   https://www.michigan.gov/documents/micontractconnect/6600029_510102_7.pdf
7. Molina Healthcare of Michigan – Contract No. 071B6600027
   https://www.michigan.gov/documents/micontractconnect/6600027_510100_7.pdf
8. Priority Health Choice – Contract No. 071B6600025

https://www.michigan.gov/documents/micontractconnect/6600025_510099_7.pdf

9. Total Health Care – Contract No. 071B6600023
   https://www.michigan.gov/documents/micontractconnect/6600023_510096_7.pdf
10. UnitedHealthcare Community Plan. Inc – Contract No. 071B6600031
    https://www.michigan.gov/documents/micontractconnect/6600031_510105_7.pdf
11. Upper Peninsula Health Plan – Contract No. 071B6600030
    https://www.michigan.gov/documents/micontractconnect/6600030_510104_7.pdf

Current Dental Health Plans (2):

1. Delta Dental Plan of Michigan – Contract No. 180000000450
   https://www.michigan.gov/documents/dtmb/180000000450_619452_7.pdf
2. Blue Cross Blue Shield of Michigan – Contract No. 180000000451
   https://www.michigan.gov/documents/dtmb/180000000451_621052_7.pdf

Current Integrated Care Organizations (7):

1. Aetna Better Health of Michigan, Inc. – Contract No. 071B5500013
   https://www.michigan.gov/documents/micontractconnect/5500013_475703_7.pdf
2. AmeriHealth Michigan, Inc. – Contract No. 071B5500012
   https://www.michigan.gov/documents/micontractconnect/5500012_475702_7.pdf
3. HAP Empowered – Contract No. 071B6600033
   https://www.michigan.gov/documents/micontractconnect/6600033_510108_7.pdf
4. Meridian Health Plan of Michigan, Inc. – Contract No. 071B5500015
   https://www.michigan.gov/documents/micontractconnect/5500015_475706_7.pdf
5. Michigan Complete Health, Inc. – Contract No. 071B5500014
   https://www.michigan.gov/documents/micontractconnect/5500014_475704_7.pdf
6. Molina Healthcare of Michigan, Inc. – Contract No. 071B5500017
   https://www.michigan.gov/documents/micontractconnect/5500017_475708_7.pdf
7. Upper Peninsula Health Plan, LLC – Contract No. 071B5500019
   https://www.michigan.gov/documents/micontractconnect/5500019_475709_7.pdf

MDHHS is required to contract with an EQRO for the analysis and evaluation of the aggregated information provided from all the Quality Assessment and Improvement Activities and the production of the results of that review. The EQR must be conducted annually and must include a health plan specific, detailed assessment of the strengths and weaknesses with respect to quality, timeliness, and access to health care services for each contracted MHP, DHP and ICO.

The Contractor must perform the reviews in accordance with the guidelines established by both federal and State law, including the State's Appropriation Boilerplate language, when applicable. For Boilerplate language see www.legislature.mi.gov ; Public Act 59 of 2013; Section 1662 (1), (2).

REQUIREMENTS

1. General Requirements

1.1. Mandatory EQRO Requirements

A. The Contractor must meet all EQRO standards of independence required under 42 CFR §438.354 (c).

1. The EQRO and its subcontractors must be independent from MDHHS and from the Michigan Managed Health Plans (MHPs), Managed Dental Plans (PAHPs), and if applicable, other MCOs, PIHPs, PAHPs, or PCCM entities that will be reviewed by the Michigan Medicaid EQR during the EQRO contract period.
2. To qualify as "independent" a State agency, department, university, or other State entity:
   a. May not have Medicaid purchasing or managed care licensing authority; and
   b. Must be governed by a Board or similar body the majority of whose members are not government employees.
3. An EQRO must not:

a. Review any MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)), or a competitor operating in the State, over which the EQRO exerts control or which exerts control over the EQRO (as used in this paragraph, “control” has the meaning given the term in 48 CFR 19.101) through:
    i. Stock ownership;
    ii. Stock options and convertible debentures;
    iii. Voting trusts;
    iv. Common management, including interlocking management; and
    v. Contractual relationships.
b. Deliver any health care services to Medicaid beneficiaries;
c. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) services, except for the related activities specified in § 438.358;
d. Review any MCO, PIHP, PAHP or PCCM entity (described in § 438.310(c)(2)) for which it is conducting or has conducted an accreditation review within the previous 3 years; or
e. Have a present, or known future, direct or indirect financial relationship with an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) that it will review as an EQRO.

B. The Contractor must meet the EQRO competence requirements under 42 CFR 438.354(b).

1. Staff with demonstrated experience and knowledge of:
    a. Medicaid beneficiaries, policies, data systems, and processes;
    b. Managed care delivery systems, organizations, and financing;
    c. Quality assessment and improvement methods; and
    d. Research design and methodology, including statistical analysis.
2. Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.
3. Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

1.2. EQRO Activity Requirements
The following activities are required in this Contract for each MCO, PAHP and ICO in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422. 153.such as:

A. Validation of Performance Improvement Projects (PIP)
Validation of performance improvement projects (§ 438.330(b)(1)) that were underway during the preceding 12 months.

1. The Contractor must provide MDHHS with an objective and comprehensive assessment of whether the MHPs and Dental Health Plans and ICO Health plans, if PIP was designed, conducted and reported in a methodologically sound manner.

2. The Contractor must evaluate the soundness and results of the PIP and evaluate PIPs per each health plan. All activities conducted must be in accordance with the specifications of 42 CFR, Part 438. Specifically, the Contractor must do the following:
    a. Develop a template to approve and evaluate the MHPs and Dental Health Plans PIP projects. These templates must include the following:
        i. Statement of intent for each PIP
        ii. PIP Evaluation
    b. Provide technical assistance to the MDHHS and to the MHPs, ICOs, and Dental Health Plans to ensure that the PIP projects are consistent with EQR protocol.
        i. In providing technical assistance to the MHPs, ICO’s, and Dental Health Plans, the Contractor must ensure that they identify best practices of individual MHPs, ICOs, and Dental Health Plans as well as potential for synergy where there is

similarity across MHPs, ICOs, and Dental Health Plans, for use as appropriate throughout Michigan.

Contractor's Plan:

Proposed Approach to Conducting the Validation of the Performance Improvement Projects (PIP)

The Contractor will use its outcome-focused approach for conducting validation of the MHPs, DHPs, ICOs (the MCOs) clinical and/or nonclinical PIPs. The Contractor's approach evaluates the MCOs' compliance with each of the 10 steps listed in the current CMS *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Using its PIP Validation Tool, the Contractor will assign a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* to each evaluation element within a given step based on the MHP/DHP/ICO documentation and study indicator outcomes. In Step IX (real improvement achieved), statistically significant improvement over the baseline must be achieved across all study indicators to receive a *Met* score. For Step X (sustained improvement achieved), the Contractor will assess for sustained improvement once each study indicator has achieved statistically significant improvement and a subsequent measurement period of data has been reported.

Using its PIP Validation Tool and standardized scoring, the Contractor also will report the overall validity and reliability of the findings as one of the following:

- *Met* = high confidence/confidence in the reported study findings.
- *Partially Met* = low confidence in the reported study findings or statistical significant improvement was achieved for some but not all of the study indicators.
- *Not Met* = reported study findings that are not credible or that statistical significant improvement has not been achieved across all study indicators.

The Contractor will designated as critical elements some of the evaluation elements pivotal to the PIP process. For a PIP to produce valid and reliable results, all critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical element receiving a score of *Not Met* will receive an overall PIP validation rating of *Not Met*. A PIP that includes accurate documentation that is in alignment with the CMS protocol requirements has high validity and reliability. Validity is the extent to which the data collected for a PIP measure its intent. Reliability is the extent to which an individual can reproduce the study results. For each completed PIP, the Contractor will assess threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible.

The goal of the Contractor's PIP validation will be to ensure that MDHHS and other key stakeholders can have confidence that any reported improvement can be clearly linked to the quality improvement strategies and processes that the MCOs conduct. The Contractor's approach for assessing and documenting PIP findings will provide a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations.

Validating if MHP, Dental Health Plans, and ICO PIPs are Methodologically Sound

The Contractor's validation approach for the MCOs will include two key components of the quality improvement process:

- Evaluation of the PIP's technical structure—the Contractor will evaluate the technical structure of each PIP to ensure the MCOs designed, conducted, and reported the PIPs in a methodologically sound manner, meeting all State and federal requirements. The Contractor's review will determine whether the PIP design (e.g., study question, population, study indicator[s], techniques, and data collection methodology/process) is based on sound methodological principles and can measure outcomes reliably. Executing this component successfully will ensure that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the PIP implementation—the Contractor will evaluate the MCOs' PIP implementation. Once designed, a PIP's effectiveness in improving outcomes depends on the data collection process, data analysis, barrier identification, and the subsequent development relevant to targeted interventions. Through this component, the Contractor will evaluate how well the MCO improves its rates by implementing effective processes.

Providing Technical Assistance to Ensure PIP Projects are Consistent with EQR Protocol

The Contractor will provide the MCOs with technical assistance throughout the process to ensure PIPs are methodologically sound and meet CMS requirements. The Contractor's technical assistance also includes:

- Providing the MCOs with timely feedback to make midcourse corrections and correct identified deficiencies.
- Providing information on industry-standard practices for conducting PIPs.

- Sharing industry best practices, common issues, and performance trends with the MCOs.
- Educating the MCOs on quality improvement science techniques that include setting aims, establishing measures, determining interventions through process-mapping and failure modes and effects analysis, and testing and evaluating interventions using Plan-Do-Study-Act (PDSA) cycles.

The Contractor will provide technical assistance to MDHHS throughout the PIP process to ensure the staff understand the CMS protocols and requirements for conducting and validating PIPs. The Contractor will conduct PIP trainings for MDHHS to ensure staff members understand the Contractor's outcome-focused approach to PIPs, the submission process, and the validation criteria.

Comprehensive Assessment and Validation Reporting

After the annual validation, the Contractor will provide MDHHS and the MCOs with a plan-specific PIP Validation Report that MDHHS has reviewed and approved. It will include:

- Background information for each PIP that is submitted and validated.
- A discussion of the types of data gathered and the data collection sources.
- A discussion of all validation steps and the methods to conduct the validation.
- Specific validation findings for each evaluation element.
- Study indicator outcomes and the statistical significance of any change in performance.
- A critical evaluation of the MCOs causal/barrier analysis processes, identified barriers, and implemented interventions.
- An evaluation of validity and reliability. For each validated PIP, the Contractor will assess and report any identified threats to the validity and reliability of findings and determine when a PIP is no longer credible.
- A discussion of conclusions drawn; identified strengths; opportunities for improvement; and recommendations to improve performance, processes, and outcomes of care.

The Contractor will develop plan-specific PIP validation reports in a modifiable format, as required by MDHHS.

B. Validation of Performance Measures

Validation of performance measures (§ 438.330(b)(2)) calculated by the State during the preceding 12 months.

An aggregate assessment of audited HEDIS® data, and other-source data, reported by the MHP is used to annually evaluate MHP performance levels of Michigan Quality Measures List of measures, such as, women's' health measures, comprehensive diabetes care measures, comprehensive asthma measures, well child measures, and etc. An aggregate assessment of audited HEDIS® data, other Dental Quality Alliance (DQA) measures and other-source data, reported by Dental Health Plans or extracted from data warehouse is also used to annually evaluate Dental Health Plan performance levels of Michigan Quality Measures.

1. The Contractor must produce a preliminary and final report on Statewide and MHP-specific performance measures, validation activities and findings. The report must include any areas of concerns for performance measures reported by MHPs and recommendations to the Agency for ways to improve and streamline validation of performance measures reported by MHPs, including whether the Agency shall pursue planning related to calculation of the measures on behalf of the MHPs. Contractor must produce a preliminary and final report on Statewide and Dental Health Plan specific performance measures, validation activities and findings for the HMP Dental and HKD program.

2. The Contractor must provide MDHHS with an aggregate assessment of HEDIS® and other-source data, (at the State's discretion) which is used by MDHHS to annually evaluate MHP performance levels.

Contractor's Plan*:*

Expertise Using NCQA Medicaid Benchmarks for Evaluation and Statistical Analysis

To assist state Medicaid agencies with their MCO performance evaluations, the Contractor will produce Excel rate spreadsheets that show MCO-level rates compared to national Medicaid benchmarks and/or rates trended

over time. The Contractor will produce the Quality Trend Report for MDHHS annually, which shows the rates for all 11 MHPs and the statewide weighted averages compared to national Medicaid benchmarks for the most recent five years.

The Contractor will create an internal HEDIS performance measure rate spreadsheet for the MDHHS annually to assist MDHHS with assigning corrective action plans (CAPs) based on HEDIS performance measure results for Medicaid MCOs. Within the HEDIS performance measure rate spreadsheets for Michigan, the Contractor will present the measure results for the most recent five years compared to the statewide average and national Medicaid benchmarks. The Contractor will also use statistical tests to compare rates from the prior year to the current year to identify statistically significant changes in performance and to compare MCO-level rates to the statewide weighted averages. MDHHS also sets minimum performance levels for the MCOs based on national Medicaid benchmarks, which MCOs must meet to avoid being placed on CAPs. The Contractor will evaluate MCO performance compared to minimum performance levels for the most recent three years to assist MDHHS in determining which MCOs will be placed on a CAP.

Expertise Using Findings to Meet HEDIS Analysis Requirements

The Contractor will use HEDIS and non-HEDIS measure results reported by MCOs to create performance measure aggregate reports for Michigan. The Contractor's aggregate reports present performance measure results for all MCOs within a state. The results are compared to benchmarks and performance targets. When possible, rates are compared to prior years to assess trends in performance.

For the Michigan HEDIS aggregate reports, the Contractor will work with MDHHS to collect performance measure data from the MHPs, ICOs, and DHPs. The Contractor will collect the HEDIS Interactive Data Submission System (IDSS) files for all HEDIS performance measure results and it will develop custom rate templates for the MCOs to report non-HEDIS performance measure information. Upon receiving the MCOs' data, the Contractor will validate the data for accuracy and will work with MDHHS to follow up with the MCOs on any potential reporting errors. Once it verifies that the performance measure data are complete and accurate, the Contractor will calculate a Michigan Medicaid weighted average for each measure in alignment with the CMS Adult and Child Core Set specifications.[1] The Contractor will provide these rates to MDHHS in an Excel document for use in the State's MACPro reporting requirements.

For each measure included in the HEDIS analyses, the Contractor will identify with MDHHS the appropriate benchmarking sources and performance targets, such as Quality Compass national Medicaid HMO benchmarks. The Contractor also will create an Excel Quality Trend Report, which is an interactive Excel file that MDHHS can use to compare MCO results and statewide weighted averages to benchmarks for all measures over the most recent five years. The Contractor will then begin incorporating the performance measures results into the aggregate report. The measures will be grouped within the report into appropriate domains of care (e.g., Women's Health, Access to Care, Appropriate Treatment and Utilization) to allow MDHHS to evaluate performance as a whole and develop strategic changes required to improve overall performance. Within each domain, the Contractor will assess the performance measure results individually, comparing MCO results to national Medicaid benchmarks, statewide weighted averages, and trending results over time. At the beginning of each section the Contractor will include an overall assessment of performance within the domain. The report also will include appendices that contain additional performance measure indicators not included in the body of the report, as well as more detailed analyses at the MCO-level. In addition, the appendices will include a detailed review of the Final Audit Reports (FARs) completed by the MCOs' licensed audit organizations, to assess whether all performance measure data were reported accurately. The Contractor will use the findings from the aggregate reports in the annual EQR technical report as part of its assessment of the quality of, access to, and timeliness of care that Medicaid beneficiaries receive.

Contractor's Plan:

Proposed Approach for Validating Performance Measure Activities

The Contractor will evaluate the NCQA HEDIS compliance audit process and will focus on reviewing the final audit results and final audit reports (FARs) that the MCOs' HEDIS licensed organizations (LOs) produce. These data sources are important documents used/generated during a typical NCQA HEDIS compliance audit. Below are the critical elements and approaches that the Contractor will use to validate the performance measure activities:

[1] Centers for Medicare & Medicaid Services. Medicaid/CHIP Health Care Quality Measures Technical Assistance Brief, March 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf. Accessed on: June 26, 2019.

- **Pre-On-Site Visit Call/Meeting**: The Contractor will verify that the LOs addressed key topics such as timelines and on-site review dates.
- **HEDIS Roadmap Review**: The Contractor will examine the FARs for evidence that the LOs completed a thorough review of all Roadmap components.
- **Software Vendor**: If an MCO uses a software vendor to produce measure rates, the Contractor will assess whether the MCO contracted with a software vendor who calculates and produces rates and if this vendor achieved full measure certification status by NCQA for the reported HEDIS measure. Where applicable, the NCQA measure certification letter will be reviewed to ensure that each measure was under the scope of certification. Otherwise, the Contractor will examine whether the LOs conducted source code review (see following step).
- **Source Code Review**: The Contractor will ensure that the LOs reviewed the MCO's programming language for both HEDIS and non-HEDIS measures if a software vendor with certified HEDIS measures was not used. Source code review will determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
- **Primary Source Verification**: The Contractor will verify that the LOs conducted appropriate checks to ensure that records used for HEDIS reporting matched the primary data source. This step will occur to determine the validity of the source data used to generate the measure rates.
- **Supplemental Data Validation**: If the MCO uses any supplemental data for reporting, the LO will need to validate the supplemental data according to NCQA's guidelines. The Contractor will verify whether the LO followed the NCQA-required approach while validating the supplemental database.
- **Convenience Sample Validation**: The Contractor will verify that, as part of the medical record review validation (MRRV) process, the LOs identified whether the MCOs were required to prepare a convenience sample and, if not, whether specific reasons were documented.
- **MRRV**: The Contractor will examine whether the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the collected data.
- **IDSS Data File Review**: The MCOs are required to submit MCO quality data to NCQA's IDSS for the submission of audited rates. The Contractor will evaluate whether there was any documentation in the FAR to demonstrate that the LOs performed a review of the IDSS.

To evaluate the MCOs' capabilities for accurate HEDIS reporting, the Contractor will review each FAR to confirm/evaluate the LO's assessment of information systems (IS) capabilities, specifically focusing on aspects of MCOs' systems that could affect the HEDIS Medicaid reporting set. NCQA's information system (IS) standards detail the minimum requirements for an organization's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. In accordance with the NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the Contractor will evaluate the extent to which the LOs evaluated IS compliance with NCQA's IS standards. The Contractor's review of the FARs will include the following verification tasks:

- Verify that the MCO's LO performed key audit elements to ensure the audit was conducted in compliance with NCQA policies and procedures.
- Examine evidence that the auditors completed a thorough review of the specific Roadmap components associated with calculating and reporting performance measures.
- Identify that the IS standards (systems, policies, and procedures) applicable for performance measure reporting were reviewed and that the auditor documented results.
- Evaluate the auditor's description and audit findings regarding data systems and processes associated with performance measure production for MCOs, where the FAR did not reference NCQA's HEDIS compliance audit procedures.

Development of a Preliminary and Final Annual Report

The Contractor will summarize its review findings and generate the preliminary and final annual reports for the MHPs, DHPs, and ICOs. These annual reports will include a description of the validation process and methodology, a review of standards and data sources, recommendations for data collection and analysis, methods used to obtain documentation, and an evaluation of the MCOs' information systems, measure-specific audit findings, and a process for reviewing final reported rates for potential bias. The report also will include any areas of concern for performance measures reported by the MCOs and a recommendation to MDHHS for ways to improve and streamline validation of performance measures reported by MCOs. The Contractor will provide the report in a modifiable format, as required by MDHHS.

C. Review of Compliance with Access, Structural and Operations Standards

A review, conducted within the previous 3-year period, to determine the compliance with the standards set forth in subpart D of this part and the quality assessment and performance improvement (§ 438.330).

MDHHS has developed a tool to annually perform compliance review surveys of each MHP and Dental Health Plan. MDHHS staff monitors adherence to Medicaid managed care regulatory requirements, standards, and contract requirements through review of the MHP and Dental Plans policies, procedures and programs and interviews with MHP and Dental Plan staff. The MHP must submit a corrective action plan for any issues identified during the survey requiring corrective action. The Contractor must review the compliance review documents and findings to determine MHP and Dental Plans compliance with the Medicaid managed care regulations. Additionally, the Contractor must provide information to MDHHS for its use in evaluating the effectiveness of the Quality Assessment and Performance Improvement Strategy.

In addition to this, for the ICO, at least once every three (3) years, the contractor will review of compliance with standards mandated by 42 C.F.R. Part 438 Subpart E, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of MDHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

The Contractor must comply with these requests for reporting/analysis within the timeframe specified in the request.

D. Network Adequacy

A review, conducted to determine the compliance with the standards set forth below and the quality assessment and performance improvement (§ 438.330).

1. Conduct Validation of Provider Network Adequacy, according to contract requirements.

2. The selected contractor must conduct activities to validate each MCO's provider network to assure compliance with 42 CFR 438.68, per 42 CFR 438.358(c)(4).

3. Prior to the final EQRO protocols being published by CMS, the selected contractor must create a methodology and tools to validate compliance of each MCO's provider network with 42CFR 438.68. All methodologies and tools must be approved by the Department.

4. Following final EQRO protocols being published by CMS, the selected contractor and the Department will agree on how to meet the requirements of 42 CFR 438.358(c)(4).

5. Secret Shoppers: - the EQRO will conduct at least one secret shopper survey, each quarter to evaluate the appointment availability of network providers in accordance with contractual requirements for each MCO and PAHP. The EQRO will share the methodology and results with the state and, if necessary, with the MCO and PAHP. The EQRO will issue recommendations to the state, MCO, and PAHP for improvement.

Contractor's Plan:

D. Network Adequacy

Proposed Approach for Validating MHP, Dental Health Plan and ICO Network Adequacy

The Contractor proposes a multiyear network adequacy validation (NAV) approach that supports a strong foundation for MDHHS' provider network oversight and establishes procedures that facilitate collecting and analyzing high-quality provider data from the MHPs, PAHPs, and ICOs (the MCOs) in accordance with contract requirements.

Although CMS has not yet published the CMS EQRO Protocol for NAV as referenced in the Medicaid Managed Care Final Rule, the Contractor has the knowledge and expertise to develop sound processes to validate each MCO's provider network to ensure compliance with 42 CFR §438.68 and 42 CFR §438.358. Before CMS

publishes this protocol, the Contractor will collaborate with and receive approval from MDHHS on a defined methodology and approach for validating the MCOs' provider networks. After publication of the CMS protocol, the Contractor will collaborate with MDHHS to review the protocol, agree on how to meet the requirements, and update the planned methodologies as needed to meet the requirements outlined in the protocol.

At the beginning of each contract year, the Contractor will conduct a NAV project kick-off meeting with MDHHS to confirm key project contacts, establish regular status meetings, determine appropriate lines of communication, and affirm the NAV goals and objectives. The Contractor also will coordinate and conduct regular status meetings with MDHHS' project team to detail tasks completed for each project phase, including an overall summary of a project's progress and upcoming efforts. As needed, the Contractor's NAV team will request NAV-specific status meetings beyond the regularly scheduled EQR progress reporting. During status meetings, the Contractor and MDHHS will discuss recommended resolutions to issues encountered during the period.

Based on the kick-off meeting, the Contractor will develop a NAV methodology for MDHHS' review and approval. Once finalized, the Contractor will use the methodology to generate subsequent study materials (e.g., data collection tools) that MDHHS approves and that provide the foundation to implement MDHHS-approved NAV methodology. During each contract year, the Contractor will conduct a detailed assessment of each MCO's network adequacy using the following phases:

Desk Review of Applicable NAV Documentation: The Contractor will collaborate with MDHHS to identify available documentation relevant to existing NAV activities and requirements (e.g., routine network monitoring reports that the MCOs submit to MDHHS). The Contractor will use desk review results in conjunction with subsequent analyses to describe each MCO's network adequacy for its beneficiary population.

Provider Crosswalk Development: In the first contract year, the Contractor will develop a provider crosswalk to establish consistent provider type and specialty definitions across the MCOs. During this foundational phase, the Contractor will collaborate with MDHHS to define provider categories for inclusion in subsequent NAV analyses. In subsequent contract years, the Contractor will review and update the provider crosswalk to reflect changes in each MCO's provider data.

Data Structure Questionnaire and MCO Data Collection: The Contractor will submit a brief data structure questionnaire to each MCO to obtain targeted information regarding the MCO's provider data structure and methods for classifying providers (e.g., methods for identifying primary care providers [PCPs] or pediatric providers).

With MDHHS' approval, the Contractor will submit a detailed data request to the MCOs for the data they used to identify beneficiaries and providers actively enrolled with the MCOs as of a specific date. Beginning in contract year two, the Contractor will supply the MCOs with a list of provider categories and the provider crosswalks developed during contract year one. The Contractor will request that the MCOs classify their provider data using the MDHHS-approved provider categories. In each year, key data elements requested will include unique provider identifier; enrollment status with the MCO; provider category; provider type; provider specialty; and PCP indicator.

Upon receiving the beneficiary and provider data, the Contractor will review the files and collaborate with the MCOs to resolve questions identified during the data review process.

Network Analyses: The Contractor will apply the crosswalk definitions to the MCOs' data to conduct the following MCO-specific network analyses:

- Network description and capacity analyses that assess the number and type of Medicaid providers, the number of network providers accepting and not accepting new patients, and beneficiary-to-provider ratios. The Contractor will stratify results by geographic region, as applicable.
- Geographic distribution analyses, in which the Contractor will use the Quest Analytics Suite software (Quest) to geocode MCOs' beneficiary and provider addresses to exact geographic locations (i.e., latitude and longitude). The Contractor will then conduct two geospatial analyses: (1) as available, the percentage of beneficiaries within predefined time and distance access standards; and (2) the average physical distance and duration of travel time to the nearest provider(s). Quest calculates the duration of travel time or driving distance between each beneficiary's address and the addresses of the nearest providers. The Contractor will use these analytic results to evaluate the extent to which each MCO's provider/beneficiary distribution meets MDHHS-defined time and distance standards.

Reporting: In addition to presenting study results in a written report, the Contractor is experienced with alternative reporting methods (e.g., oral presentations, data workbooks, and dashboards), as applicable to the analyses. The Contractor will close each annual NAV by producing MCO-specific and aggregate annual reports, delivering one report per MCO and one aggregate report each for MHPs, DHPs, and ICOs, and providing any supplemental NAV deliverables that MDHHS requests. At a minimum, each MCO-specific report will contain an introduction and MCO-specific findings, conclusions, recommendations, and follow-up from previous years'

recommendations, if applicable. Each aggregate report will contain, at a minimum, an executive summary; summary findings for the MHPs, DHPs or ICOs; conclusions; recommendations; and follow-up from previous years' recommendations or MDHHS initiatives, if applicable.

Before drafting the reports for each contract year, the Contractor will submit a formatted report outline for MDHHS' review and approval. This process will allow the Contractor to incorporate MDHHS' feedback on the report structure early in the reporting phase, improving overall efficiency during MDHHS' report review. The Contractor will submit draft reports to MDHHS for review and approval based on a mutually agreeable project timeline so the MDHHS staff can have sufficient review time. After MDHHS' review and approval, the Contractor will produce and provide MDHHS with an electronic copy of each final report, per the MDHHS-approved study timeline. The Contractor will provide the report in a modifiable format, as required by MDHHS.

Proposed Approach for Sampling and Conducting Secret Shopper Surveys to Assess Appointment Availability

The Contractor will conduct at least one secret shopper telephone survey each quarter to assess MCOs' adherence to contract requirements for appointment availability, wait time standards, and providers' acceptance of new beneficiaries. To allow sufficient time to collaborate with MDHHS on project startup, methodology and script development, and any pilot surveys, the Contractor proposes to conduct three surveys during the first contract year and four in each subsequent contract year. However, the Contractor will collaborate with MDHHS during contract initiation to confirm whether the Contractor will conduct three or four quarterly secret shopper surveys during the first contract year.

With a secret shopper approach, providers' offices typically require personally identifying information when discussing appointment availability for existing patients; as such, the Contractor will collaborate with MDHHS during project startup to determine the most effective survey method(s) to address MDHHS' goals. Regardless of whether the quarterly telephone surveys involve revealed callers or secret shoppers, the Contractor's approach for conducting telephone surveys includes the following phases:

Develop Study Methodology: In addition to reviewing existing provider network documentation (e.g., appointment availability standards), the Contractor will organize a kick-off meeting with MDHHS to confirm study goals, data sources, and the overall project plan. Because beneficiaries may choose from more than one MCO in most geographic regions, the Contractor anticipates an overlap in network providers. The Contractor will collaborate with MDHHS during the study design phase to develop a sampling approach and secret shopper survey script that minimizes the burden on providers' offices while accounting for MDHHS' study goals and the MCOs' geographic overlap. The Contractor will develop a detailed methodology defining the eligible population of providers (i.e., the sample frame), sampling protocol, data collection process, study indicators, and survey script. The Contractor also will produce a comprehensive analysis plan with fundamental definitions and the methods used to calculate each study indicator. The Contractor will provide the study methodology for MDHHS' review and approval before proceeding to the survey, and it will implement the same methodology for each quarterly survey during the contract year.

Develop Sampling Protocol: To minimize the possibility of provider data updates during the survey's data collection phase, the Contractor will generate survey samples using the most recently available MCO provider files and will provide the lists of survey cases for MDHHS' reference.

The Contractor will describe the sampling approach in the approved methodology, with the following general parameters:

- Each survey will include providers throughout Michigan. The Contractor will collaborate with MDHHS to determine the sample distribution, such that sampled provider locations reflect the geographic distribution of each MCO's providers.
- At MDHHS' direction, the sample may include out-of-state providers practicing in states or counties contiguous to Michigan.
- Based on its Medicaid provider survey experience, the Contractor will recommend an oversample (i.e., an increase in each MCO's sample size) to account for sampled providers not contacted due to erroneous telephone data or refusal to participate in the survey.
- The Contractor will ensure that the number of sampled cases corresponds to a 95 percent confidence level and a minimum margin of error of ±5 percent for each MCO.

Develop Survey Script: During each survey's study design phase, the Contractor will develop a telephone script for MDHHS' feedback and approval. In assembling the proposed script, the Contractor will consider the following topics:

- MDHHS' survey objectives (e.g., appointment availability, acceptance of new beneficiaries, and/or data accuracy validation).

- The intended survey methodology (i.e., secret shopper survey).
- The intended survey respondents and call length.
- The intended order and grouping of survey elements.

To ensure surveys are applicable to the provider specialty, the Contractor provider survey call staff within the network adequacy validation activity team will consult the Contractor staff members with expertise in Medicaid care management, utilization management, and clinical services. In selecting potential scenarios for secret shopper surveys, the Contractor will consider the time of year the survey is administered to minimize the likelihood of receiving referrals to urgent or emergency care rather than obtaining potential appointment availability. For example, a secret shopper caller requesting an appointment for an upper-respiratory illness during the winter influenza season may have a different call experience than a caller requesting a primary care appointment at the same time of year for a suspected ear infection.

In addition to the interviewer's spoken text, the Contractor's secret shopper survey scripts include skip logic and supplemental instructions to guide the interviewers. Secret shopper survey scripts also include personal scenarios to ensure consistent data collection across interviewers. For example, interviewers may be instructed to conduct the survey as though they are Medicaid beneficiaries moving to Michigan from out of state and are attempting to arrange an appointment for a well-check with a PCP. The Contractor's secret shopper scripts also note that interviewers are instructed not to schedule appointments or leave voice mail.

Develop a Standardized Data Collection Tool: After MDHHS reviews and approves the detailed methodology, the Contractor will develop an electronic data collection tool to support interviewers' data collection, interviewer oversight, and subsequent analyses and reporting. To ensure consistent data collection, the Contractor will train interviewers using written tool instructions and practice survey calls.

The Contractor's standardized data collection tools control skip logic among applicable survey elements and will allow interviewers to populate only valid response values for each survey element. To maintain data integrity, provider data for sampled providers are prepopulated in the tool, and interviewers are not able to alter original provider data values.

Additionally, the Contractor has developed a robust telephone survey process as a result of extensive experience implementing secret shopper telephone surveys among Medicaid providers. Interviewers undergo project-specific training with a dedicated analytics manager to standardize calls and how data from these calls are recorded in a web-based abstraction tool. For each interviewer, the analytics manager reviews 100 percent of calls placed during the first week after the training period and a minimum of 10 percent of calls thereafter. Call reviews will verify that the interviewers are using the web-based tool and secret shopper survey script as intended and that survey data are accurately abstracted and documented in the web-based tool. The analytics manager will hold daily briefings with all callers to share issues identified during the day and to reinforce and refresh training concepts. Data inconsistencies identified in the abstraction tool will result in the analytics manager following up with the original caller. During the data collection phase, if the Contractor identifies call scenarios that cannot be resolved through internal discussion or an additional call to the provider, the Contractor will contact MDHHS for guidance (e.g., systematically incorrect telephone numbers for a provider network).

Conduct Telephone Survey and Analysis: The Contractor will administer the telephone survey calls among sampled provider locations, consistent with the approved methodology and script. The Contractor will perform interviewer oversight to assure consistent, quality data collection among and interviewers.

Before it begins analysis, the Contractor will review survey data using the SAS®[2] statistical software package to assess data validity, including frequency distributions, valid range checks, and logical field-to-field comparisons. Validation questions or concerns will be resolved with the analytics manager. The Contractor will then conduct analyses, generating survey indicator results according to MDHHS-approved study materials. Another analyst will validate all results independently to ensure the validity and accuracy of analytic findings.

Reporting: After each quarterly telephone survey, the Contractor will prepare for the State and each MCO an aggregate report that includes MCO-specific results and recommendations for improvement. At a minimum, each quarterly report will contain information on the survey methodology and data tables presenting aggregate and MCO-specific findings. Concurrent with each quarter's draft report, the Contractor will submit MCO-specific workbooks (i.e., flat files) to MDHHS containing the provider-level quarterly survey results.

Before generating the first quarterly report and flat files, the Contractor will submit a formatted report outline and flat file template for MDHHS' review and approval. The Contractor will use same MDHHS-approved deliverable templates for all quarterly survey reports during each contract year. This process will allow the Contractor to

[2] SAS is a registered trademark of the SAS Institute, Inc.

incorporate MDHHS' feedback on the report and flat file structure early in the reporting phase, improving overall efficiency during MDHHS' report review.

After the quarterly survey analyses, the Contractor will submit the draft report and flat files to MDHHS for review and approval based on a mutually agreeable project timeline so the MDHHS staff will have sufficient review time. The Contractor will then incorporate MDHHS' feedback and deliver the final reports and flat files to MDHHS in a modifiable format, as required by MDHHS. If necessary, the Contractor will deliver the reports to each MHP, DHP, and ICO.

1.3. Additional Activities Required

In addition to the requirements above, MDHHS may request for each PAHP MCO ICO additional ad hoc information/reporting/analysis of the Contractor for the following activities as described in 438.310(c)(2) for each MCO or PAHP performed by using information derived during the preceding 12 months including but limited to:

A. Validation of encounter data reported by an MCO, PAHP and ICO (described in § 438.310(c)(2)).
B. Administration or validation of consumer or provider surveys of quality of care.
C. Calculation of performance measures in addition to those reported by an MCO, PAHP, (described in § 438.310(c)(2)) and validated by an EQRO in accordance with paragraph (b)(1)(ii) of this section.
D. Conduct of performance improvement projects in addition to those conducted by an MCO, PAHP, ICO (described in § 438.310(c)(2)) and validated by an EQRO in accordance with paragraph (b)(1)(i) of this section.
E. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
F. Assist with the quality rating of MCOs, and PAHPs consistent with § 438.334.

1.4. CAHPS

A. **CAHPS Requirements**

1. The Contractor must have experience in survey research and implementation and be a NCQA certified contractor, experienced in CAHPS® survey methods and protocol, with the ability to conduct member satisfaction surveys which meet NCQA specifications for HEDIS® submission, as applicable.

2. The Contractor must provide statistically valid data for comparisons between health plans in each MDHHS program and for each population surveyed and provide information in a format which can be used in communicating program performance to consumers, health plans, the legislature, CMS, and State agencies via detailed, analytic reports. The information provided should aid participating health plans and programs in identifying areas for quality improvement efforts.

    a. The Contractor must develop full analytic reports for both the HMP and the adult MHP survey findings for each year of the Contract, using each health plan's CAHPS® member and summary level data provided by MDHHS, the individual health plans, or their CAHPS® contractor.

    b. The Contractor must develop full analytic reports for both HMP dental and HKD Dental survey findings for each year of the Contract, using each dental plan's CAHPS® member and summary level data provided by MDHHS, the individual dental plans or their CAHPS® contractor.

    c. The Contractor must work with MDHHS to develop a system of quality metrics for MHP, HKD and HMP Dental which may include CAHPS® Dental Plan Survey and a Michigan Medicaid Managed Care Consumer Guide for HKD patients.

    d. The Contractor must have NCQA HEDIS® and CAHPS® certification.[3]

[3] https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/

e. The Contractor must have access to and utilize national benchmarks in its comparative analysis of MHPs and Fee for Service (FFS). The Contractor must be able to provide insight and recommendations regarding survey design, use and national survey activity changes.

Contractor's Plan:

Proposed Approach to CAHPS® 5.0 Survey Administration

The Contractor will coordinate with MDHHS to determine survey design and methodology, approach, and timing of the surveys each year.

Survey Preparation

The Contractor will develop and provide MDHHS with administrative forms, text for cover letters and postcards, and sample frame instructions that include direction on the eligible population, the file layout, and valid values for each element.

Sampling

The Contractor will review the sample frame files for usability, readability, and file format, to include:

- Verifying that the format follows the requested file layout.
- Ensuring that all values included in the file are valid.
- Checking for the amount of missing data that could impact survey response rates.
- Verifying that the record counts match those that MDHHS provides.

After review of the sample frame files, the Contractor will select a sample of beneficiaries. The table following provides an overview of the sample sizes that will be selected for each population.

Population	Number of Samples	Sample Size per Sample
Adult FFS	1	1,350
Child FFS and MHP	12	1,650
Child CSHCS (MHP and FFS)	11	1,650
Adult HMP	11	1,350
Adult HMP Dental	11	1,350
Adult ICO	7	1,350
Adult ICO HCBS	1	2,000
HKD Dental	2	1,650

De-duplication will be performed to ensure that no household receives more than one survey.

Survey Instrument

The Contractor will use the most appropriate version of the CAHPS survey instrument for each population, as outlined in the table below.

Population	Survey Instrument
Adult FFS	Adult Medicaid CAHPS 5.0 Health Plan Survey with the HEDIS supplemental item set
Child FFS and MHP	Child Medicaid 5.0 Health Plan Survey with the HEDIS supplemental item set (without the CCC measurement set)

Child CSHCS (MHP and FFS)	Customized version of the Child Medicaid 5.0 Health Plan Survey with the CCC measurement set
Adult HMP	Adult Medicaid CAHPS 5.0 Health Plan Survey with the HEDIS supplemental item set
Adult HMP Dental	Adult Dental CAHPS Health Plan Survey
Adult ICO	Adult Medicaid CAHPS 5.0 Health Plan Survey with the HEDIS supplemental item set
Adult ICO HCBS	CAHPS Home and Community-Based Services (HCBS CAHPS) Survey
HKD Dental	Customized Child Dental Health Plan Survey[4]

The Contractor will incorporate up to five close-ended supplemental questions into the survey. Surveys will be offered in both English and Spanish.

Survey Administration

The Contractor will oversee the survey administration activities and its subcontractor will administer the surveys using a mixed-mode methodology that includes a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up. The mail component of the project will consist of an initial questionnaire and cover letter, a reminder postcard, a second questionnaire and cover letter to nonrespondents, and a second reminder postcard to nonrespondents. Beneficiaries will receive an English version of the survey with the option to complete the survey in Spanish. The cover letter included with the English version will have a Spanish cover letter on the back side informing beneficiaries that they can call a toll-free number to request a Spanish version. All mail items will be sent first-class mail and carry a toll-free help line number for respondents who have questions about the study. Before the mailings, addresses will be passed through the National Change of Address system.

Approximately three weeks after the second survey mailing, the Contractor's subcontractor will initiate telephone follow-up with all non-responders to the mailed survey. There will be up to three telephone follow-up calls for each nonrespondent. TeleMatch will be used to verify the telephone numbers for each case. The questionnaires will be fully programmed into a CATI system. Custom software within the CATI system will review the calling history of each number and analyze the patterns of call dispositions. Thus, calls will be distributed across different days and times throughout each week of the telephone field phase.

Reporting

Reporting of Survey Results

The Contractor will prepare an aggregate report of findings for each program from each survey. As part of its reporting, the Contractor will include:

1. **Executive Summary**—Containing a survey introduction, report overview, and key findings from the survey results.
2. **Dispositions and Response Rates**—A count of the number of completed surveys and response rates.
3. **Demographics**—A breakout of the demographic characteristics of respondents to the survey (e.g., age, gender, race, ethnicity, general health status).
4. **National Comparisons**—Comparisons of rates to national benchmarks, if applicable.
5. **Plan Comparisons**—Comparisons of the plans' results to the program average.
6. **Trend Analysis**—A comparison of current survey results to previous year results, when available.
7. **Key Drivers of Beneficiary Experience Analysis**—An analysis at the program level to identify potential items for quality improvement efforts for key global ratings.
8. **Reader's Guide**—A description of the survey administration (e.g., sampling, survey modes), data analyses methodologies, and limitations and cautions.

The Contractor will provide the report in a modifiable format, as required by MDHHS.

B. CAHPS Services

[4] AHRQ does not have a developed dental survey for the child population.

Contractor must provide Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

1. The Contractor must have the ability to analyze survey data in a succinct and detailed, yet easily understood, manner and must report meaningful findings including, but not limited to, comparisons between MHPs or Dental Health Plans,CSHCS, ICOs, MDHHS programs or populations, or year to year findings, as applicable.

2. The Contractor must develop program specific work plans in Microsoft Project for the MHP, FFS, HKD, HMP Dental, ICOs and CSHCS programs. The plan must include, but not be limited to, a timeline for each survey project and associated tasks.

3. The Contractor must create databases(s) and commercial quality surveys, in either color or black and white and administer survey tools, and collect data for the MHP, HMP Adult, FFS, HKD, HMP Dental, ICOs and CSHCS programs.

4. The Contractor must complete all data preparation, analyses, and delivery of reports for the MHP, FFS, HKD, HMP Dental, ICOs and CSHCS programs. This includes analysis of the adult CAHPS® survey data from each of the contracted MHPs and the development of a single Statewide report for each year of the Contract.

5. The Contractor must conduct the adult FFS survey each year of the Contract. Surveys of the MHP and FFS child populations must be conducted every other year approximately beginning November 1, 2019. Surveys for the CSHCS population will also be conducted every other year beginning approximately October 1, 2019. Surveys for ICOs will be conducted each year of the Contract. Surveys for HKD, HMP Dental population must be conducted every year beginning approximately January 1, 2020.

6. The Contractor must provide technical assistance for MHP's, Dental Plans, CSHCS, ICOs and MDHHS staff.

7. CAHPS survey administration protocol must be done with mixed mode methodology consisting of two questionnaire mailings, two reminder postcard mailings and up to three phone interviews.

8. The survey must be administered in English with the option to complete a survey in Spanish. The English survey cover letters must be printed in English on one side and Spanish on the reverse side with a toll-free number that members can call to request to complete a Spanish version of the survey.

9. Up to five supplemental questions may be added to the CAHPS survey questionnaire (all close-ended) administered to each surveyed population. The survey questionnaires must be no longer than eight pages in length.

10. The contractor must conduct Adult Medicaid CAHPS surveys for one sample of the Adult FFS population (i.e. one adult FFS sample). All 11 MHPs must contract with separate survey vendors to administer the Adult CAHPS surveys to their own adult Medicaid populations.

11. The contractor must conduct Child Medicaid CAHPS surveys for one child FFS populations and 11 Child MHPs for a total of up to 12 Child Medicaid samples.

12. The contractor must conduct CSHCS Surveys for two FFS populations and nine samples of MHPs for a total of 11CSHCS samples.

13. The contractor must conduct Adult CAHPS Surveys for seven ICO health plans for a total of seven plan-level samples.

14. The contractor must conduct Adult CAHPS Surveys for seven ICO health plans for a total of seven plan-level samples who are receiving in-home services and community-based services.

15. The contractor must conduct Adult CAHPS surveys for 11 HMP health plans for a total of 11 plan-level samples for physical health.

16. The contractor must conduct Adult CAHPS surveys for 11 HMP (Dental benefits) plans for a total of 11 plan-level samples for oral health.

17. The contractor must conduct Healthy Kids Dental CAHPS Dental Plan level Survey for 2 Dental PAHPS for a total of two plan-level samples.

1.5. EQRO Deliverables

The following is a preliminary analysis of the major tasks involved for developing the end product of this project. 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. **EQRO Compliance Review Deliverables**

The Contractor must produce a detailed, MHP/DHP/ICO-specific technical report that describes the manner in which the data from all EQR-related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished to Medicaid managed care enrollees. The Contractor must also produce a dental plan-specific report. These reports must include the following for each activity conducted:

1. An executive summary in the Statewide analysis.
2. A description of the methodology used to conduct the analyses.
3. A narrative summary of the importance of each measure selected for analysis.
4. A description of the caveats concerning interpretation of each measure's results.
5. A comparison of the results to national Medicaid benchmarks.
6. A model to group measures across domains that apply to specific population groups.
7. Interpretation of results.
8. A validation of Performance Measures from the health plans.
9. Recommendations for improvements.
10. An assessment of each MHPs, DHPs and ICOs strengths and weaknesses with respect to the quality, timeliness of, and access to health care services furnished to Medicaid enrollees.
11. Wherever methodologically appropriate, comparative information for each quality measure relative to industry benchmarks, including national Medicaid averages, and Statewide MHP, DHP performance averages. Where feasible, the analysis of MHP, DHP data shall include comparisons with previous plan performance. The Contractor must provide comparative information for Medicaid quality measures relative to industry benchmarks.
12. Wherever possible, the data and results from all EQR-related activities shall be analyzed and reported separately for individuals with and without special health care needs.
13. An assessment of the extent to which each MHP, DHP and ICO's has addressed the recommendations for quality improvement made by the EQRO during the previous year's review.

Findings to be used by the Contractor to produce the technical report evaluating MHP, HMP Dental and HKD performance includes, but is not limited to:

1. Agency's annual MHP, HKD and the ICO Compliance Review done once in three years.
2. Validation of Performance Measures results
3. MHP, HKD and ICO quality improvement projects
4. Annual adult CAHPS® and child CAHPS© and other consumer surveys studies, including findings from any strategic report produced on Consumer survey data

5. Clinical and/or nonclinical focused studies conducted by EQRO during preceding year (State's discretion)

B. **HEDIS® Analysis**

As part of the MDHHS annual reporting requirements, MHPs must submit copies of the audited Medicaid HEDIS®, Integrated Diagnostic Support System (IDSS) and Final Audit report. An aggregate assessment of HEDIS® data is used by MDHHS to annually evaluate MHP performance.

1. The Contractor must comparatively review MHP quality of care outcomes and performance measures and utilize the findings as part of this task for inclusion in EQR technical report.

2. The Contractor must utilize the most current NCQA Medicaid benchmarks in order to appropriately evaluate and perform HEDIS® analysis.

3. The Contractor must perform a comprehensive review and analysis of the contracted Michigan MHPs IDSS results for each reporting year of this Contract, beginning with reporting year 2018. A comprehensive review and analysis must be conducted for the Michigan Dental Health Plans for each reporting year of this Contract. This task must include:

    a. Making recommendations to MDHHS about appropriate benchmarks.
    b. Creating electronic file extracts containing the Medicaid HEDIS® results reported for each measure by each MHP and Dental Health Plans and agreed upon benchmarks from a national database.
    c. Providing the data in hard copy format and electronically in an MDHHS software compatible format.
    d. Determining the level of statistical analysis that is appropriate, given the quality and quantity of the HEDIS® Medicaid data submitted by the MHPs and the Dental Health Plans.
    e. Performing statistical tests to compare health plan performance to Statewide means, NCQA's Quality Compass benchmarks and goals, where appropriate, or conducting descriptive comparative analysis, trends with MDHHS approval.
    f. Comparing MHP and Dental Health Plans performance to the prior year's results.
    g. Constructing a model to group measures across domains that apply to specific population groups, such as children and pregnant women.
    h. Will give this HEDIS data to MDHHS for entering into the Federal MACPro system

C. **Optional Focused Study Deliverable**

As an optional activity, and at the sole discretion of MDHHS, MDHHS may choose to conduct an external review of focused clinical and/or non-clinical topic(s) as part of MDHHS's review of quality outcomes, timeliness of and access to, services provided by MHPs and Dental Health Plans. The Contractor may conduct a focused study using a method consistent with the CMS established EQR Activity protocol as part of Task A- EQR Technical Report.

D. **Consumer Guide Analysis Deliverables**

MDHHS requires each MHP and Dental Health Plans to perform a consumer satisfaction survey of Medicaid managed care adult enrollees including HMP Dental program and HKD enrollees. The results of the survey will be provided to the Contractor to provide a comparative analysis of the MHP annual HEDIS® and other-source data and CAHPS® data to support the development of the Michigan Medicaid Consumer Information Guide.

The Contractor must develop a quality rating system for the HKD program using the comparative analysis of the Dental Health Plans annual HEDIS® and other-source data and CAHPS® data to support the development of the Michigan Medicaid Consumer Information Guide for the HKD program. The analysis helps to support MDHHS public reporting of health plan performance information. The

Contractor must utilize the results of HEDIS® Analysis and CAHPS® findings to perform the following tasks:

1. Perform statistical tests to compare MHP and Dental Health Plans' performance to Statewide means, benchmarks, and goals where appropriate, and conduct descriptive comparative analysis using NCQA benchmarks; and

2. The Contractor must propose two methodologies to calculate MHP and Dental Health Plans specific results for use in the Consumer Guide and/or Performance Bonus using Medicaid 50th percentile benchmark or Michigan Weighted Average (Aggregate Rate) as the reference point and an appropriate benchmark for HKD.

    a. The Contractor must utilize CAHPS® and/or HEDIS® measures within a category. When using CAHPS® measures, only composites or global ratings, not single questions, must be utilized. The Contractor must calculate MHP-specific results and provide these results to MDHHS. The calculations must be based upon MHP-specific HEDIS® and CAHPS® rates compared to Michigan aggregate rates or comparable benchmarks.

    b. The Contractor must maintain the existing five categories in the current Consumer Guide, and modify as determined by MDHHS:

        i. Doctor Communication and Service
        ii. Getting Care
        iii. Keeping Kids Healthy
        iv. Taking Care of Women
        v. Living with Illness/Preventing Complications

    c. The Contractor must deliver an Excel file for each category that has the following:

        i. Individual MHP rates and Dental Plan rates
        ii. Michigan aggregate rate or comparable benchmarks
        iii. Difference between MHP, Dental Health Plans and aggregate rate or benchmarks
        iv. 95% confidence interval
        v. Indication if MHP rate and Dental Health Plan rate are significantly higher, lower, or no different from the Michigan aggregate rate or comparable benchmark. This indication must be based on T-tests and a significance level of 95%

Contractor's Plan:

To support its goals for creating the consumer guides, the Contractor will first work with MDHHS to determine the appropriate data to include in the analysis, including HEDIS Interactive Data System Submission (IDSS) performance results, CAHPS survey results, and other source data, as appropriate. The Contractor will then collaborate with MDHHS to identify appropriate performance measures and survey results to include in the consumer guide analysis. For CAHPS measures, the Contractor will ensure the use of only composite or global ratings in the consumer guide analysis. Once the Contractor determines the data sources and selects the measures, it will develop two methodologies for MDHHS' consideration. The methodologies will outline the Contractor's proposed approach for comparing MCO performance to MDHHS-defined benchmarks, such as the Michigan weighted average (i.e., statewide mean), MDHHS performance goals, and appropriate national Medicaid benchmarks (e.g., Quality Compass). The difference between an MCO's score and the established benchmark will determine the MCO ratings (e.g., above average, average, or below average) for individual performance measures and overall categories based on tests of statistical significance. Annually, the Contractor will propose a new alternative methodology based on MCOs' feedback and a review of national literature. The Contractor will compare results calculated for the alternative methodology to the results from the MDHHS-selected methodology from the prior year. For the MHP consumer guide, the Contractor will maintain the five categories addressed in the Guide to Michigan Medicaid Health Plans – A Quality Checkup, January 2019

(Doctors' Communication and Service, Getting Care, Keeping Kids Healthy, Taking Care of Women, and Living With Illness/Preventing Complications). For the DHP consumer guide, the Contractor will work with MDHHS to determine appropriate categories to organize the HEDIS, CAHPS, and other data sources or to determine if only measure-level comparisons to national benchmarks will be derived. Additionally, the Contractor will perform a descriptive analysis using NCQA Medicaid benchmarks for each performance measure or category to provide additional MCO-level information to MDHHS.

Upon MDHHS approval of the selected consumer guide methodology, the Contractor will assign a lead analyst and a validation analyst for the consumer guide analysis. The lead analyst will develop production code using SAS® software to generate MCO-specific results and output for the consumer guide. After the lead analyst completes analyses using all performance measure results, the validation analyst will create separate programming code and compare results with those generated by the lead analyst. Both analysts will work to reconcile any differences in the results before submitting the consumer guide results to MDHHS. The Contractor also will check results for reasonability based on available data sources (e.g., NCQA benchmarks, historical results), where appropriate.

The Contractor will submit Excel spreadsheets to MDHHS with the MCO consumer guide results for review and approval. The spreadsheets will have an agreed-upon format but will include, at a minimum, individual MCO measure rates; Michigan aggregate rate or a comparable benchmark; the difference between the MCOs' category rates and the Michigan aggregate rate (i.e., statewide average) or benchmark; the results of the significance testing at the 95 percent confidence interval; and the final results of the consumer guide analysis at the category level (i.e., indicating if the MCO was significantly higher, lower, or the same as the Michigan aggregate rate or applicable benchmark). The Contractor will work with MDHHS to determine the most appropriate format to display the category-level results (e.g., a three-level rating scale using apples or stars).

E. **Network Adequacy Deliverables**

1. Provider panel requirements established by MDHHS for each of their entire designated service areas in order to ensure access to medically necessary Medicaid covered services. MCOs and PAHPs are required to submit provider information in a manner specified by MDHHS to ensure they meet the minimum provider panel requirements. Additionally, ICO networks are required to be analyzed annually to assure compliance with time and distance standards. All plans submit files on a monthly basis to the appropriate system as specified by MDHHS. Validation of this information is necessary to ensure accuracy of provider information listed in directories that are used by consumers. The validation activities will be completed for all plans and the EQR-will validate according to CMS protocols when applicable. Additional requirements will be added related to Network Adequacy Standards when CMS releases new protocols related to 42 CFR § 438.358, section (b)(iv).

   For the validation activities described above, the Contractor must do the following:

   a. Develop a study methodology that describes the evaluation approach;
   b. Develop a standardized data collection tool;
   c. Develop a sampling methodology;
   d. Collect and analyze data; and
   e. Prepare a report for each plan for each MCO and PAHP, containing plan-specific findings, and an overall report for the MCOs and one overall report for the PAHPs.

2. **Secret Shopper Survey**
   To ensure members can appropriately access providers, MDHHS will use secret shopper survey (quarterly telephone surveys) among a sample of providers for MCOs and PAHPS and ICOs to determine appointment availability information for new and existing members.

   The contractor must conduct the following:

   a. Develop and/or update a study methodology describing the evaluation approach;

   b. Develop and/or update a standardized data collection tool;

c. Develop a sampling methodology. Use the most recent monthly managed care plan provided provider data files for drawing a sample of providers and develop a standard protocol for sampling;
   i. A single statewide survey with proportional distribution of sampled cases shall be used.
   ii. An appropriate oversample will be used to account for unreachable providers.
   iii. Sample will ensure a 95 percent confidence level and minimum margin of error of plus 5 percent.

d. Develop a script in collaboration with MDHHS; and

e. Conduct telephone surveys among sampled provider locations. The Contractor will be required to calculate, for each plan, a performance measure that uses the results from the telephone surveys.

   After each survey, the Contractor will provide MDHHS with:
   i. A report that includes data tables with aggregate and plan-specific results.
   ii. Plan-specific workbooks (flat files) containing provider-level survey data results.

1.6. CAHPS Deliverables

A. **FFS Adult Survey Deliverables:**

1. For each Contract year, the Contractor must conduct a CAHPS® survey of adult Medicaid beneficiaries who are enrolled in the FFS program. The most current CAHPS® protocol must be followed where appropriate and feasible, using the mixed methodology option for survey implementation.

2. The Contractor must use the eligible member files supplied to them by MDHHS to construct the sample frames. The source for the sample frame will be MDHHS administrative records. The questionnaire to be utilized for the survey of the adult FFS population will be the current adult version of the CAHPS® or CAHPS® FFS survey tool. (If no FFS version exists or is not applicable, the Contractor shall modify the available CAHPS® tool accordingly). The exact content of all survey tools and mailings will be subject to approval by MDHHS.

3. The sample frame records obtained from MDHHS administrative records will contain beneficiary addresses.

Contractor's Plan:

In an effort to maximize response rates, the Contractor will review for usability the sample frame files that MDHHS supplies and will check for missing data (e.g., addresses, phone numbers) that could impact survey response rates. After sample selection, the Contractor also will update sampled beneficiaries' addresses using the National Change of Address database.

4. The Contractor must also have a process in place for telephone data collection for non-respondents which complies with NCQA protocol. The Contractor must have methods to obtain the telephone numbers, in the event that MDHHS and/or the health plans cannot supply complete and accurate telephone lists.

Contractor's Plan:

Proposed Process for Telephone Data Collection for Non-Respondents

Approximately three weeks after the second survey mailing, the Contractor will follow up by telephone with all non-responders to the mailed survey. Non-responders include beneficiaries whose completed surveys were not yet received as well as beneficiaries whose mailed surveys were returned as undelivered (not at that address).

Before the telephone portion of the survey administration begins, the Contractor will use TeleMatch to verify the telephone numbers for each case. This process validates and updates contact information as necessary.

The cover letter included with the English version of the survey will have a Spanish cover letter on the back side informing beneficiaries that they can call a toll-free number to request a Spanish version of the survey. All mail items are sent first-class mail and include a toll-free help line number for respondents who have questions about the study.

The questionnaires will be fully programmed into the CATI system and will take an estimated 15 minutes. The Contractor will distribute calls across different days and times throughout each week of the telephone field phase, and will make a series of at least three CATI calls to each non-respondent.

5. The Contractor must obtain, from NCQA, the detailed file specifications, the data collection tool for reporting both aggregate and member level data, and the specifications to calculate the composite scores.

6. The Contractor must report all data as specified by NCQA, including response rates. All automated data tapes and other files submitted to NCQA, and/or MDHHS must be cleaned, edited, and contain appropriate documentation to facilitate analysis. Due dates for all materials will reflect those as defined by NCQA and applicable for the reporting period.

7. The Contractor is responsible for the data entry, cleaning, analysis and proper storage of all results obtained, following NCQA protocol where applicable.

8. The Contractor must produce and deliver the analysis report of the adult population. An initial draft version of the report is due to the MDHHS Program Manager within one month of completion of the survey. The final report must be delivered within 90 days following survey completion. For CAHPS® surveys, survey completion is defined as receipt of NCQA validated member and summary level files by the Contractor.

B. **(MHP and FFS) Child Surveys Report**

1. The Contractor must conduct a CAHPS® survey of the child Medicaid beneficiaries who are in the FFS program and enrolled in the MHP. These populations will be surveyed starting FY2018. The number of MHPs is subject to change each year and may reflect the number of sample sizes.

   Following the HEDIS®/CAHPS® protocol, surveys must be conducted for each MHP and FFS child populations. Sources of the sample frame records will include the participating MHPs and MDHHS administrative records. The Contractor must use the eligible member files supplied to them by MDHHS and/or MHPs to construct the sample frames per NCQA specifications.

2. The Contractor must obtain verification from the MHP that a certified auditor has verified the sample frame. Each MHP's member files must be audited by a certified HEDIS® auditor prior to the constructing of the sample frame files.

3. The questionnaires to be utilized for the surveys must be the most current CAHPS® child survey.

4. The Contractor must modify the managed care tool accordingly if no applicable FFS child survey tool exists.

5. The Contractor must obtain and document NCQA approval of each questionnaire version when required by HEDIS®/CAHPS® protocol. The core questionnaires may include supplemental question modules as determined by MDHHS. The exact content of all survey tools and mailings will be subject to approval by MDHHS. Copies of the approval notices shall be provided to MDHHS.

6. The Contractor must implement the CAHPS® child surveys and CAHPS® child FFS surveys according to the specifications as described in the current HEDIS® Specifications for Survey Measures, Volume 3, and/or subsequent versions, or as otherwise described by NCQA, using the mixed methodology option of mail, followed by telephone surveys for non-respondents.

7. The Contractor must utilize standard questionnaires and cover letters provided by NCQA and modified by MDHHS, as appropriate.

8. The Contractor must obtain prior NCQA approval for any modifications to the MHP child surveys and/or mailings.

9. The Contractor must provide the option of allowing respondents to the child survey to choose a Spanish version.

10. The Contractor must conduct survey administration and data collection for non-respondents that is in accordance with NCQA protocol. Approximately three weeks after the second survey mailing, telephone follow-up must be implemented for all non-responders to the mailed survey. Before the telephone portion of the survey administration begins, the Contractor must use a telephone number verification system for verifying the telephone numbers for each case.

11. In the event that MDHHS and/or the health plans cannot supply complete and accurate telephone lists, the Contractor must use a telephone number verification system for verifying beneficiaries' telephone numbers approximately three weeks after the second survey mailing, before the telephone portion of the survey administration begins.

12. The Contractor must obtain, from NCQA, the detailed file specifications, the data collection tool for reporting both aggregate and member level data, and the specifications to calculate the composite scores.

13. The Contractor must report all data as specified by NCQA, including response rates. All automated data tapes and other files submitted to NCQA, MDHHS, and/or MHPs must be cleaned, edited, and contain appropriate documentation to facilitate analysis. Due dates for all materials must reflect those as defined by NCQA and applicable for the reporting period.

14. The Contractor is responsible for the data entry, cleaning, analysis and proper storage of all results obtained, following NCQA protocol where applicable.

15. The Contractor must produce and deliver separate analysis reports of the adult and child FFS and child MHP populations.

16. Initial draft versions of each report are due to the MDHHS Program Manager within one month of completion of the surveys. Final reports must be delivered within 90 days following survey completion.

17. For CAHPS® surveys, survey completion is defined as receipt of NCQA validated member and summary level files by the Contractor.

C. **MHP Adult CAHPS® Survey Report**

1. The Contractor must create a detailed analytical report using the adult CAHPS® member level and summary level survey data from each of the MHPs. The report must include an overall assessment summarizing each MHP's performance including comparisons to the MHP weighted and non-weighted average score and/or current benchmarks for the ratings and composite measures, as well as other selected survey questions.

2. The Contractor, in collaboration with MDHHS, must develop the communication document to MHPs requesting the data for this report.

3. The NCQA generated member and summary level files will be made available to the Contractor from MDHHS, the individual MHPs and their CAHPS® contractor.

4. The initial draft version of the report is due to the MDHHS Program Manager within one month of the Contractor's receipt of the data files. Final reports must be delivered no later than 90 days following receipt of the data files

D. **Children's Special Health Care Services (CSHCS) CAHPS Report**

1. The Contractor must conduct a member satisfaction survey of beneficiaries enrolled in the CSHCS program.

2. The Contractor must conduct surveys of the CSHCS population using the current HEDIS®/CAHPS® Child Survey protocol as a framework and Dental Plan CAHPS® Survey protocol.

3. The Contractor must use the eligible member files supplied to them by MDHHS to construct the sample frames. Sources of the sample frame records must be MDHHS administrative records. The questionnaires to be utilized for the surveys will be modifications of the current HEDIS®/CAHPS® Child and Dental Plan Surveys as determined by MDHHS with the Contractor's assistance.

4. The Contractor must format and produce the survey tool/questionnaire. The core questionnaires may include supplemental modules as determined by MDHHS. The exact questionnaire content of all survey tools will be subject to approval by MDHHS.

5. The Contractor must implement surveys with the guidance of HEDIS®/CAHPS® specifications and protocol including two survey mailings with telephone follow-up and reminder postcards, modified as necessary for the populations being surveyed.

6. The Contractor must utilize survey cover letters, and reminder postcards modified by MDHHS as necessary. The cover letter sent with the second Questionnaire will differ from the letter sent with the first questionnaire.

7. The Contractor must develop (sampling plan, sample frame, production of survey tool(s) and all respondent notices) and implement the survey plan (creation of database(s), administration of survey tool(s) and collection of data).

8. The sample frame records obtained from MDHHS administrative records must contain beneficiary addresses.

9. The Contractor must conduct survey administration and data collection for non-respondents that is in accordance with NCQA protocol. Approximately three weeks after the second survey mailing, telephone follow-up will be implemented for all non-responders to the mailed survey. Before the telephone portion of the survey administration begins, the Contractor must use a telephone number verification system for verifying the telephone numbers for each case.

10. In the event that MDHHS cannot supply complete and accurate telephone lists, the Contractor must use a telephone number verification system for verifying telephone numbers prior to survey administration beginning.

11. The Contractor is responsible for the data entry, cleaning and analysis of all results obtained.

12. The Contractor must produce and deliver an analysis report as defined by MDHHS.

13. The initial draft version of the report is due to the MDHHS Program Manager within one month of completion of the survey. Final reports must be delivered no later than 90 days following survey completion.

E. **Integrated Care Organizations (ICO) Adult CAHPS Report and CAHPS Home and Community-based services (HCBS) Report**

1. Contractor must conduct Adult CAHPS® Surveys and CAHPS HCBS survey for up to seven health plans participating in Michigan's Dual Demonstration project.

2. Contractor must conduct two surveys- one for the dually eligible adult population and a survey specifically targeting beneficiaries who are receiving home and community-based services. See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

3. Contractor must provide MDHHS with weekly disposition reports detailing the distribution of survey dispositions, including number of surveys completed, ineligibles, and non-respondents, as well as response rates during the survey fielding period.

4. The Contractor must produce two Adult Statewide Reports with aggregate and plan-specific findings, tab and banner books (crosstabulations), and de-identified member-level raw data files representing CAHPS® Survey results for the up to seven health plans.

F. **HMP Adult CAHPS® Statewide Report**

1. The Contractor must create a detailed analytical report using the adult HMP CAHPS® member level and summary level survey data from each of the MHPs. The report must include an overall assessment summarizing each MHP's performance including comparisons to the MHP weighted and non-weighted average score and/or current benchmarks for the ratings and composite measures, as well as other selected survey questions.

2. The Contractor, in collaboration with MDHHS, must develop the communication document to MHPs requesting the data for this report.

3. The NCQA generated member and summary level files will be made available to the Contractor from MDHHS, the individual MHPs and their CAHPS® contractor.

4. The initial draft version of the report is due to the MDHHS Program Manager within one month of the Contractor's receipt of the data files. Final reports must be delivered no later than 90 days following receipt of the data files

G. **HMP Adult Dental Benefits CAHPS® Statewide Report**

1. The Contractor must create a detailed analytical report using the adult HMP dental CAHPS® member level and summary level survey data from each of the MHPs. The report must include an overall assessment summarizing each MHP's dental performance including comparisons to the MHP weighted and non-weighted average score and/or current benchmarks for the ratings and composite measures, as well as other selected survey questions.

2. The Contractor, in collaboration with MDHHS, must develop the communication document to MHPs requesting the data for this report.

3. The NCQA generated member and summary level files will be made available to the Contractor from MDHHS, the individual MHPs and their CAHPS® contractor.

4. The initial draft version of the report is due to the MDHHS Program Manager within one month of the Contractor's receipt of the data files. Final reports must be delivered no later than 90 days following receipt of the data files

H. **Healthy Kids Dental (HKD) CAHPS® Statewide Report**

1. The Contractor must create a detailed analytical report using the HKD CAHPS® member level and summary level survey data from each of the DHPs. The report must include an overall assessment summarizing each MHP's performance including comparisons to the DHP weighted and non-weighted average score and/or current benchmarks for the ratings and composite measures, as well as other selected survey questions.

2. The Contractor, in collaboration with MDHHS, must develop the communication document to DHPs requesting the data for this report.

3. The NCQA generated member and summary level files will be made available to the Contractor from MDHHS, the individual DHPs and their CAHPS® contractor.

4. The initial draft version of the report is due to the MDHHS Program Manager within one month of the Contractor's receipt of the data files. Final reports must be delivered no later than 90 days following receipt of the data files

1.7. Transition

The Contractor must work with the State and/or the previous contractor within 90 days for an orderly transition. Contractor must provide a detailed transitional plan timeline to the State within 15 calendar days after contract award. The Contractor must allow as many personnel as practicable to attend meetings and receive hardcopy and/or electronic files to help maintain the continuity and consistency of the services required by the Contract. The Contractor must comply with reasonable detailed specifications for all Services/Deliverables previously provided to the State to properly provide the Service/Deliverables required under this Contract.

The Contractor must acquire any software required to meet Services and Deliverable criteria under this Contract. This must include any documentation being used by the Contract to perform the Services under this Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level.

1.8. Training

The Contractor must provide the following training: Identify onsite, office or internet-based training requirements for MDHHS and MHPs or Dental Health Plans and ICOs as required. Trainings would include, but not limited to: CAHPS and HEDIS requirement, exchange of data in accordance with State and MHPs and Dental Health Plan's data systems.

Contractor must also provide training and technical assistance in project requirement such as PIP to MHPs, Dental Health Plans and MDHHS. The Contractor must explain its training capabilities and any training that is included in its proposal.

Contractor's Plan:

Administering Required Training

Trainings will include CAHPS and HEDIS requirements and the exchange of data among the MDHHS, MHP, and DHP data systems. Additionally, the Contractor will provide project-specific training and technical assistance to MDHHS, MHPs, ICOs, and DHPs, as necessary, to ensure successful completion of each EQR activity included as part of the Michigan EQRO contract.

Training Capabilities and Proposed Trainings

The Contractor will offer insight, recommendations, and proposals during each stage of the contract and for all aspects of the EQR activities. An important activity within the Contractor's EQRO contracts is the provision of consultation, training, and technical assistance to state Medicaid agencies and MCOs at both the staff and

committee levels. Because of its experience, the Contractor is able to anticipate pitfalls that may occur in all aspects of EQR activities and provide technical assistance and training to overcome those pitfalls.

The Contractor's approach to providing technical assistance and training to MDHHS and its contracted MCOs will be flexible and responsive to the specific needs, culture, and MDHHS MCO contract requirements, and EQR activity requirements. Drawing from its pool of subject-matter experts, the Contractor plans and executes professional education, training, and technical assistance projects to create a successful environment for learning and to provide the best opportunity for improving performance and outcomes. The Contractor will provide technical assistance and training that:

- Addresses areas that have the highest priority with the probability of producing improvement associated with (1) an aspect of care related to quality, access, timeliness, and/or beneficiary health outcomes; (2) improved performance related to meeting specific MDHHS contract requirements; and (3) strategies for engaging providers and beneficiaries in embracing early detection of disease and illness, early intervention, prevention, and health promotion activities to achieve overall population health.
- Facilitates improvement activities in an area where performance has not met MDHHS' expectations.
- Facilitates accurate and timely reporting of technical data to CMS or other stakeholders.

Assessing the Need for Technical Assistance and Training

The Contractor will identify and provide the necessary technical assistance and training to the MCOs—individually or as a group, as needed—to ensure that each MCO is fully prepared for the role it will play within an activity. The Contractor will review for the MCO the timelines and due dates for its active participation; the staff, information, and other resources it will need for the activity; and how it will communicate the outcome and results of the activity (usually a report). If the Contractor discovers that MCO staff members are struggling with EQR concepts or with meeting data submission requirements, it will notify MDHHS and recommend a specific technical assistance or training strategy specific for the MCO to guide them through the EQR activity.

Proposed Approach for Providing Technical Assistance and Training

The Contractor's approach to conducting technical assistance includes specific and proven steps, as follows:

- Once the need for technical assistance or training on a topic is identified, the Contractor will develop and submit to MDHHS for review a detailed written plan for providing assistance on that topic. The plan will include the following:
  - A detailed approach for providing technical assistance or training, including the topic and the target audience.
  - A determination of how the technical assistance or training will be provided to MDHHS and/or the MCOs (i.e., on-site, conference call, webinar, and/or in writing).
  - In addition to the Contractor Project Director, the Contractor activity leaders and staff members who will conduct the technical assistance or provide the training.
  - The anticipated date for completing the technical assistance or training session.
  - The anticipated goals and expected outcome of the technical assistance or training session.
- Upon receiving MDHHS' written approval, the Contractor will implement the plan and initiate the planning and design for technical assistance or training.
- The Contractor will provide the agenda and handouts for the presentations and will facilitate the discussion.

The Contractor will observe and assess each MCO's participation as the training is conducted, will report to MDHHS regarding any concerns, and will provide recommendations for additional technical assistance or training interventions to ensure activities are conducted as successfully as possible.

For MCOs that are new to the Medicaid managed care program or have not been involved in a particular EQR activity, the Contractor will provide technical assistance by offering introductory webinars to help them become familiar with activities in which they will participate. The Contractor offers technical assistance and training throughout the cycle of each EQR activity via teleconferences and webinars so projects stay on task and MCOs are fully aware of their roles and responsibilities throughout the activity. The Contractor will submit all technical assistance and training presentation materials to MDHHS for review and approval before conducting technical assistance and training with the MCOs.

Proposed Examples of Technical Assistance and Training That Could be Offered

The Contractor staff members are prepared to provide technical assistance to MDHHS and the MCOs in the form of written communication, conference calls, in-person meetings, and written reports as needed to achieve the most positive outcomes.

In addition to assisting the MCOs on their participation in mandatory and optional EQR activities, the Contractor's staff members are prepared to provide technical assistance and training to MDHHS and the MCOs for the following activities:

- Selecting performance measures used for quality improvement (for both MDHHS and MCOs).
- Developing and tracking PIPs and other quality initiatives (for both MDHHS and MCOs).
- Developing EQR result summaries to share with MDHHS leadership (for MDHHS).
- Identifying national healthcare trends and best practices that can be shared with the MCOs (for both MDHHS and MCOs).
- Providing clinical consultation for program evaluation (for MDHHS).

Providing instruction to the MCOs for continuous evaluation and improvement of health initiatives.

2. Acceptance

2.1. Acceptance, Inspection and Testing

The State will use the following criteria to determine acceptance of the Contract Activities:

At the introduction of each task (identified below), the Contractor must seek written comments and approvals, from MDHHS, of final versions of each:

A. Detailed work plan
B. Template
C. Methodology
D. Draft or interim report
E. Final report
F. Invoices for payment

The Contractor must submit each task listed above, to the Program Manager, who will then confer with appropriate management to obtain final approvals. Once the Program Manager has confirmed that all deliverables have been met satisfactorily in their detailed work plan, then acceptance will be given.

This process will also allow for discussion, when applicable, during the established bi-weekly conference calls, or during special conference calls when deemed necessary by either or both parties.

3. Staffing, Organizational Structure and Governing Body

3.1. Contractor Representative

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

Contractor Representative:

Project Director: Ms. Lee Ann Dougherty, MHA.

Project Manager and backup for Ms. Dougherty will be Ruth Ruby, BSN, RN.

3.2. Customer Service Toll-Free Number

The Contractor must specify its toll-free number for the State to make contact with the Contractor Representative. The Contractor Representative must be available for calls during the hours of 8 am to 5 pm ET.

Contractor's Toll-Free Number:

1-844-472-4426

3.3. Work Hours

The Contractor must provide Contract Activities during the State's normal working hours Monday – Friday, 7:00 a.m. to 6:00 p.m. ET, and possible night and weekend hours depending on the requirements of the project.

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

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

Key Personnel assigned to this Contract must have, at a minimum, the following:

A. Demonstrated experience and knowledge of:
   1. Medicaid recipients, policies, data systems, and processes;
   2. Managed care delivery systems, organizations, and financing;
   3. Quality assessment and improvement methods; and
   4. Research design and methodology, including statistical analysis.

B. Clinical and nonclinical skills necessary to carry out EQR and CAHPS® activities related to the Contract.

C. NCQA HEDIS® & CAHPS® certification.[5]

NCQA Certifications

The Contractor both an NCQA-licensed organization for conducting NCQA HEDIS audits and an NCQA-certified HEDIS survey vendor. The Contractor's subcontractor, DataStat, is also an NCQA-certified HEDIS CAHPS vendor

EQRO/CAHPS Key Personnel Table

Contact Name	Position Title	Phone	Email
Michigan Project Management Team			
Lee Ann Dougherty, MHA	Project Director, State & Corporate Services (S&CS)	Toll Free: 844.472.4426 Direct: 614.360.2746 Mobile: 614.477.9735	LDougherty@hsag.com
Ruth Ruby, BSN, RN	Project Manager, S&CS	Toll Free: 844.472.4426 Direct: 602.321.4080	RRuby@hsag.com
Validation of Performance Improvement Project (PIP) Team			
Christi Melendez, RN, CPHQ	Associate Executive Director, Performance Improvement Projects (PIPs), S&CS	Toll Free: 844.472.4426 Direct: 602.801.6875	CMelendez@hsag.com
Performance Measurement, HEDIS and non-HEDIS® Team			
Mariyah Badani, MBA, CHCA	Director, Audits, S&CS	Toll Free: 844.472.4426 Direct:	MBadani@hsag.com

[5] https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/

		602.801.6657	
Consumer Guide Analysis Team			
Raymond Berens, BA	Associate Director, DSAA	Toll Free: 844.472.4426 Direct: 602.801.6828	RBerens@hsag.com
CAHPS®			
Amber Saldivar, MHSM	Director, DSAA	Toll Free: 844.472.4426 Direct: 602.801.6822	ASaldivar@hsag.com
Focused Study Team			
Amy Kearney, BA	Director, DSAA	Toll Free: 844.472.4426 Direct: 602.801.6886	AKearney@hsag.com
EQRO Technical Report and Production Team			
Lee Ann Dougherty, MHA	Project Director, S&CS	Toll Free: 844.472.4426 Direct: 614.360.2746 Mobile: 614.477.9735	LDougherty@hsag.com
Ruth Ruby, BSN, RN	Project Manager, S&CS	Toll Free: 844.472.4426 Direct: 602.321.4080	RRuby@hsag.com
Alicja Wierzchowska, MA	Associate Director, Reports Team, S&CS	Toll Free: 844.472.4426 Direct: 602.801.6744	AWierzchowska@hsag.com
Raymond Berens, BA	Associate Director, DSAA	Toll Free: 844.472.4426 Direct: 602.801.6828	RBerens@hsag.com
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Prior to any proposed staffing changes, the Contractor must submit, to the MDHHS Program Manager for final approval, the Contractor's project organizational structure.

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

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

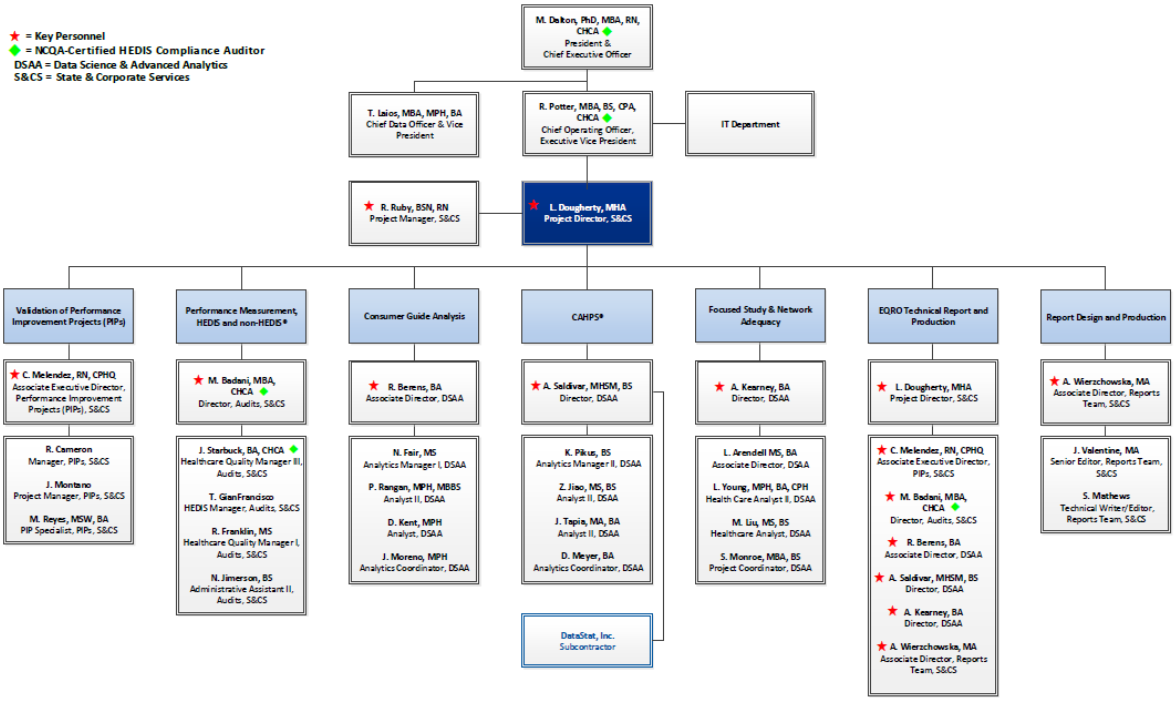
(ii) If Contractor fails to assign a replacement to shadow the removed Key Personnel for at least 30 calendar days, in addition to the $25,000.00 credit specified above, Contractor will credit the State $833.33 per calendar day for each day of the 30 calendar-day shadow period that the replacement Key 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.

3.5. Non-Key Personnel
The Contractor may have additional staff who are not considered key, but whose roles are critical to the successful completion of MDHHS projects.

3.6. Organizational Chart
The Contractor must provide an overall organizational chart that details staff members, by name and title, and subcontractors.

A.1 – HSAG Michigan EQRO Services and Customer Satisfaction Survey
Project Team Organization Chart



HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA) which stands for Healthcare Effectiveness Data and Information Set.
CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) which stands for Consumer Assessment of Healthcare Providers and Systems.

3.7. Disclosure of Subcontractors

If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

The legal business name; address; telephone number; a description of subcontractor's organization and the services it will provide; and information concerning subcontractor's ability to provide the Contract Activities.

The relationship of the subcontractor to the Contractor.
Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.

A complete description of the Contract Activities that will be performed or provided by the subcontractor.

Subcontractor	
Legal business name and full address.	DataStat, Inc. 3975 Research Park Drive Ann Arbor, MI 48108
State in which business was incorporated.	Michigan
Phone number.	734.994.0540
Description of subcontractor's organization and the services it will provide.	DataStat, Inc., located in Ann Arbor, Michigan, was founded in 1988 by researchers from the University of Michigan Institute for Social Research and the School of Public Health. Its founders also included business people with corporate research and marketing backgrounds. DataStat has grown to a staff of more than 25 research professionals, with an automated, high-capacity mail facility; a Computer Assisted Telephone Interviewing (CATI) facility with 100 stations and more than 100 telephone interviewers; and a web survey facility that runs from in-house servers and is protected by full firewall security and 256-bit encryption. All facilities were

	designed in-house and are located under one roof. DataStat typically handles more than 100 active survey projects at any given time. The mail production system can go from blank paper to 50,000 completed mail packets per day, with 100 percent video scan accuracy. The DataStat CATI system handles about 60,000 hours of interviewing time each year. Further, the web survey system has collected hundreds of thousands of interviews over the past several years.
Description of the Contract Activities that will be performed or provided by the subcontractor.	DataStat will assist with the CAHPS survey tasks, performing the following tasks: • Sampling procedures, including obtaining and verifying the sample frame, selection of the sample, and assignment of a unique identification number to each sampled beneficiary. • Data collection procedures, to include implementing the mail and telephone phases. • Data receipt and data entry/scanning procedures. • File development and submission processes. • Tracking of key survey events in the survey management system. • Survey administration quality control activities. • Confidentiality and data security.
Information concerning subcontractor's ability to provide the identified Contract Activities for their business.	DataStat possesses the following equipment, facilities, specialty staff qualifications, and services: • All necessary equipment and facilities to administer large-scale mail surveys, including in-house printing/production capabilities. • Modern, well-equipped CATI survey capabilities. • Extensive data processing and computing resources. • In-house groups that specialize in coding, data capture, file creation, editing, tabulation, customized programming, and advanced statistical consultation and analysis. DataStat has provided consistent and exceptional work in data quality and maximizing response rates. The Contractor has completed numerous survey projects with DataStat and has been pleased with the quality of work on these projects.
The relationship of the subcontractor to the Contractor.	DataStat is a contractual partner to the Contractor for conducting the CAHPS survey tasks.
If the Contractor has a previous working experience with the subcontractor, provide the details of that previous relationship.	The Contractor and DataStat have been partnering on survey activities across the country for more than 20 years.

3.8. Security

The Contractor may be subject the following security procedures:

A. The Contractor's staff may be required to make deliveries to or enter State facilities.

Contractor's Plan:

A. Complying with Security Procedures during Deliveries to or Entering State Facilities

a. Ensuring the Security of State Facilities

The Contractor staff members entering the State's facilities to conduct business will ensure security of those facilities by following any MDHHS-required procedures for announcing their name, position title, the State staff members they are visiting, and the purpose of the visit, and they will sign in on any logbook, as needed. If MDHHS requires it, the Contractor staff members also will allow MDHHS security personnel and/or program staff members to accompany them while in the building. If MDHHS requires the Contractor staff members to wear State-issued identification badges, including that a photo be taken for such a badge, the Contractor staff members will comply with the request and follow MDHHS' procedures.

b. Using Uniforms and ID Badges

The Contractor staff members do not wear uniforms. Each wears an Contractor-issued identification badge that includes the staff member's photo, name, position title, and an expiration date. Upon request, the Contractor staff members visiting the State's facilities will provide the MDHHS staff and/or security with a personal business card containing name, position title, email address, and phone number, along with the Contractor's corporate headquarters' address and phone number.

c. Conducting Background Checks

The Contractor currently performs criminal history record background checks on every employee before he/she commences work. The Contractor retains the results for the duration of his/her employment. Such results can be made available to the State at any time.

The Contractor will use Career Builder Employment Screening for these background checks and is responsible for all associated costs.

d. Scope of Background Checks

The Contractor's background checks include:

- Social Security Number trace.
- County criminal felony and misdemeanor search for each location the person has lived in the previous seven years.
- A multi-jurisdictional national criminal index search that includes the Office of Inspector General (OIG)—which includes the Excluded Parties List System (EPLS) —and the National Sex Offender Registry.
- A professional license verification.
- An education verification.
- Three employment verifications.
- A motor vehicle/driver's history report.

As described under Ensuring the Security of State Facilities above, the Contractor personnel conducting business at MDHHS' facilities will comply with a request to wear a State-issued identification badge.

B. Ensure continuous control of security access to confidential or protected information by immediately adjusting or removing any individual whose employment status or position has changed. Ensure continuous control of security access to confidential or protected information and to ensure that individual accesses are immediately removed or adjusted for any individual whose employment status or positions have changed.

C. Ensure all resources assigned to perform contract services, including subcontractors, follow federal and state laws, rules and regulations and shall not use Medicaid data for any purposes outside of the scope of this contract without the express written consent of the Department.

D. Assure all reports and performance measures will be reported in the aggregate and will not include member identifiable information.

E. Abide by all federal and state laws, rules and regulations including Federal law 42 CFR Part 2 which prohibits unauthorized disclosure of these records. Comply with appropriate security protocols to include procedures defined in HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act. All transactions designed for the storage and retrieval of the information shall meet these requirements.

F. Provide the Department with its summary and analytic data files used to conduct the evaluation upon request. These files must be: Organized; Clearly labeled; and, Accompanied by a data dictionary.

G. Work with the Department to assure that appropriate data use agreements are in place to obtain needed data.

H. Ensure any and all electronic transmission or exchange of any State of Michigan data shall be secured using Secure File Transfer Protocols using no less than 128bit encryption and appropriate transfer mechanisms.

I. Ensure the secure storage of the Department-provided data, ensuring any storage media is encrypted, locked and retain control of access of any storage areas and or facilities.

J. Ensure confidential information in paper form is stored in a separate, secure room or in locked file cabinets, accessible to authorized personnel only. Any data authorized for destruction shall be destroyed according to Federal, State, and industry standards and certified and documented in writing by the data destruction agent.

K. Ensure all data, and any copies thereof, are returned to the Department upon Department request or no later than the contract expiration date, whichever occurs first, unless otherwise instructed by the Department to destroy copied data.

L. **Security Breach Notification:** If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and State laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State, in writing, any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by the Contract within 10 days of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

3.9. SPECIFIC STANDARDS

IT Policies, Standards and Procedures (PSP)

Contractors are advised that the State has methods, policies, standards and procedures that have been developed over the years. Contractors are expected to provide proposals that conform to State IT policies and standards. All services and products provided as a result of this RFP must comply with all applicable State IT policies and standards. Contractor is required to review all applicable links provided below and state compliance in their response.

Public IT Policies, Standards and Procedures (PSP): http://www.michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html

Note: Not all applicable PSP's are available publicly. Controlled PSP's applicable to the RFP are available after signing and returning to the State the required Nondisclosure Agreement (NDA) agreement. Failure to return a signed NDA may be grounds for disqualification.

Secure Web Application Standard

Contractor's solution must meet the State's Secure Application Development Standards as mandated by the State.

Secure Application Development Life Cycle (SADLC)

Contractor is required to meet the States Secure Application Development Life Cycle requirements that include:

Security Accreditation

Contractor is required to complete the State Security Accreditation process for the solution.

Application Scanning

On-Premise solutions

The State may scan the application using its application scanning tools. Contractor will need to provide the resources, at its sole expense, to complete any analysis remediation and validation required by the results of the scan.

Externally hosted solutions
Contractor is required to grant the right to the State to scan either the application code or a deployed version of the solution; or in lieu of the State performing a scan, Contractor will provide the State a vulnerabilities assessment after Contractor has used a State approved application scanning tool. These scans must be completed and provided to the State on a regular basis or at least for each major release.

For COTS or vendor owned applications, Contractor, at its sole expense, must provide resources to complete the scanning and to complete the analysis, remediation and validation of vulnerabilities identified by the scan as required by the State Secure Web Application Standards.

Types of scanning and remediation may include the following types of scans and activities

- Dynamic Scanning for vulnerabilities, analysis, remediation and validation
- Static Scanning for vulnerabilities, analysis, remediation and validation
- Third Party and/or Open Source Scanning for vulnerabilities, analysis, remediation and validation

Infrastructure Scanning

On-Premise solutions
The State may scan the application using its infrastructure scanning tools and remediate infrastructure vulnerabilities internally.

Externally hosted solutions
A Contractor providing Hosted Services must scan the infrastructure at least once every 30 days and provide the scan's assessment to the State in a format that can be uploaded by the State and used to track the remediation.

Acceptable Use Policy
To the extent that Contractor has access to the State's computer system, Contractor must comply with the State's Acceptable Use Policy, see http://michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html. All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State's system. The State reserves the right to terminate Contractor's access to the State's system if a violation occurs.

Look and Feel Standard
All software items provided by the Contractor must adhere to the following Look and Feel Standards: http://www.michigan.gov/documents/som/Look_and_Feel_Standards.

ADA Compliance
The State is required to comply with the Americans with Disabilities Act of 1990 (ADA), and has adopted a formal policy regarding accessibility requirements for websites and software applications. The State is requiring that Bidder's proposed Solution, where relevant, to level AA of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0. Bidder may consider, where relevant, the W3C's Guidance on Applying WCAG 2.0 to Non-Web Information and Communications Technologies (WCAG2ICT) for non-web software and content. The State may require that Bidder complete a Voluntary Product Accessibility Template for WCAG 2.0 (WCAG 2.0 VPAT) or other comparable document for the proposed Solution.
http://www.michigan.gov/documents/dmb/1650.00_209567_7.pdf?20151026134621

SUITE Documentation
In managing its obligation to meet the above milestones and deliverables, the Bidder is required to utilize the applicable State Unified Information Technology Environment (SUITE) methodologies, or an equivalent methodology proposed by the Bidder. The Bidder is required to review http://www.michigan.gov/suite and demonstrate how each PMM/SEM requirement will be met. Bidders wishing to use their own documents must submit an example of the document that will be substituted. If the Bidder deems a document to be non-

applicable, please provide reasons for the determination. The State reserves the right to give final approval of substituted documents and items marked as non-applicable.

SUITE's primary goal is the delivery of on-time, on-budget, quality systems that meet customer expectations. SUITE is based on industry best practices, including those identified in the Project Management Institute's PMBoK and the Capability Maturity Model Integration for Development. It was designed and implemented to standardize methodologies, processes, procedures, training, and tools for project management and systems development lifecycle management. It offers guidance for efficient, effective improvement across multiple process disciplines in the organization, improvements to best practices incorporated from earlier models, and a common, integrated vision of improvement for all project and system related elements.

While applying the SUITE framework through its methodologies is required, SUITE was not designed to add layers of complexity to project execution. There should be no additional costs from the Bidder, since it is expected that they are already following industry best practices which are at least similar to those that form SUITE's foundation.

SUITE's companion templates are used to document project progress or deliverables. In some cases, Bidders may have in place their own set of templates for similar use. Because SUITE can be tailored to fit specific projects, project teams and State project managers may decide to use the Contractor's provided templates, as long as they demonstrate fulfillment of the SUITE methodologies.

Agency Specific Standards
Because the system contains Federal Tax Information, Contractor shall comply with all application security requirements outlined in IRS Publication 1075 including, but not limited to, the Exhibit 7 Safeguarding Contract Language embedded below:


CONTRACT LANGUAGE FOR TECH


Exhibit 7 General Services Requirement

See the following links for further information:

- https://www.irs.gov/privacy-disclosure/additional-requirements-for-publication-1075
- https://www.irs.gov/pub/irs-pdf/p1075.pdf

4.1. Project Management
Although there will be continuous liaison with the Contractor team, the Department's Program Manager will meet (via phone conference) bi-weekly at a minimum, with the Contractor's Program Manager for the purpose of reviewing progress, revising the project plan as necessary, and providing necessary guidance to the contractor in solving problems which may arise. These weekly meetings will also be used for review and feedback by MDHHS during the survey report process. Bi-weekly contacts may occur less frequently subject to the consent of both parties.

A. **MHP (Child Version) and FFS (Adult and Child Versions)**
   1. The Contractor must submit a copy of the finalized adult and child survey materials (e.g. survey tools, letters and reminder mailings) as approved by NCQA, if applicable, for each health plan or program, along with a copy of the NCQA approval, if applicable, to MDHHS. Each of the participating MHPs will receive a copy of the materials being sent to their members along with a copy of the NCQA approval. All of these materials must be provided to MDHHS and MHPs at least 10 business days prior to the start of the data collection phase of the project. The survey tools, letters, and reminder mailings must also be provided in electronic format to the MDHHS Program Manager.

   2. The Contractor must produce and share data tables, files and reports with various audiences (e.g. program, health plans, Department, etc.).

a. The Contractor must produce one electronic copy of the cross table reports for each plan and program, including all questionnaire items and the CAHPS® composite variables (indexes/scales) displayed by respondent demographic results (e.g., age, sex, time in plan, overall satisfaction, health status) for all choices for all questions, shown in their final distribution. Summary statistics such as means, standard deviations, and standard errors must also be included for many items and constructed variables.

b. The Contractor must produce a report documenting final disposition of each plan and program adult and/or child surveys. The report items must be presented as program totals and by individual MHPs and must include the following information:

i. sample size(s)
ii. number of surveys mailed
iii. number of surveys completed
iv. number of mail returns
v. number of ineligibles
vi. telephone follow-up status
vii. number and status of non-respondents
viii. response rate

c. The Contractor must provide a complete set of member and summary level data files each participating MHP and to MDHHS after validation by NCQA, if applicable.

3. The Contractor must produce full analysis reports of the MHP child, and FFS adult and child survey findings. The Contractor must follow HEDIS®/CAHPS® methodology as described in the most current HEDIS® Specifications for Survey Measures, Volume 3, and subsequent versions, utilizing statistical analysis to detect differences at a 95% confidence level. At a minimum, the full analysis report must include the following:
    a. An executive summary outlining the history/background of the CAHPS® survey, as applicable, and a detailed description of the key findings on a Statewide and plan-to-plan basis, e.g. demographic and survey responses.
    b. Plan-to-plan and FFS comparisons for each of the composite scores and ratings questions to include the Statewide overall average score for each composite and rating. A comparison to current Medicaid Child CAHPS® benchmarks will be requested for the Child MHP survey.
    c. Trending analyses of the composites and ratings using CAHPS® data collected from the previous years by MDHHS.
    d. A report of MHP plan-to-plan and FFS comparisons for selected survey questions, to be determined jointly by the Contractor and MDHHS, illustrated in color graphs/tables/charts.

B. **MHP (Adult Version)**

The Contractor must produce a full analysis report of the adult MHP survey findings using the NCQA generated member and summary level data obtained from MDHHS, the individual MHPs, or their vendors. From which entity the data will be obtained must be finalized in the work plan. The Contractor must follow HEDIS®/CAHPS® methodology as described in current HEDIS® Specifications for Survey Measures, Volume 3, and subsequent versions, utilizing statistical analysis to detect differences at a 95% confidence level. At a minimum, the full analysis report for CAHPS® must include the following:

1. An executive summary outlining the history/background of the CAHPS® and describing the key findings on a Statewide basis.

2. A report of plan-to-plan comparisons for each of the composite scores and ratings questions to include the overall mean and weighted and non-weighted average score for each composite and rating with comparisons to current Medicaid Adult CAHPS® benchmarks. The Contractor must have access to the benchmarks as published in the NCQA Quality Compass.

3. Key drivers as well as trending analyses of the Statewide composites and ratings may be requested by MDHHS as part of the analytic report. The trending analyses would use data collected from the previous one to two years by MDHHS and/or the MHPs.

4. A report of plan-to-plan comparisons for the demographic and access questions, the Advising Smokers to Quit Rate, as well as other selected survey questions, to be determined jointly by the Contractor and MDHHS and illustrated in color graphs/tables/charts.

D. **HMP (Physical Health)**

The Contractor must produce a full analysis report of the adult HMP survey findings using the NCQA generated member and summary level data obtained from MDHHS, the individual MHPs, or their vendors. From which entity the data will be obtained must be finalized in the work plan. The Contractor must follow HEDIS®/CAHPS® methodology as described in current HEDIS® Specifications for Survey Measures, Volume 3, and subsequent versions, utilizing statistical analysis to detect differences at a 95% confidence level. At a minimum, the full analysis report for CAHPS® must include the following:

1. An executive summary outlining the history/background of the CAHPS® and describing the key findings on a Statewide basis.

2. A report of plan-to-plan comparisons for each of the composite scores and ratings questions to include the overall mean and weighted and non-weighted average score for each composite and rating with comparisons to current Medicaid Adult CAHPS® benchmarks. The Contractor must have access to the benchmarks as published in the NCQA Quality Compass.

3. Key drivers as well as trending analyses of the Statewide composites and ratings may be requested by MDHHS as part of the analytic report. The trending analyses would use data collected from the previous one to two years by MDHHS and/or the MHPs.

4. A report of plan-to-plan comparisons for the demographic and access questions, as well as other selected survey questions, to be determined jointly by the Contractor and MDHHS and illustrated in color graphs/tables/charts.

E. **HMP (Dental Health)**

The Contractor must produce a full analysis report of the adult HMP dental survey findings and summary level data obtained from MDHHS, the individual MHPs, or their vendors. From which entity the data will be obtained must be finalized in the work plan. The Contractor must follow HEDIS®/CAHPS® methodology as described in current HEDIS® Specifications for Survey Measures, Volume 3, and subsequent versions, utilizing statistical analysis to detect differences at a 95% confidence level. At a minimum, the full analysis report for CAHPS® must include the following:

1. An executive summary outlining the history/background of the CAHPS® and describing the key findings on a Statewide basis.

2. A report of plan-to-plan comparisons for each of the composite scores and ratings questions to include the overall mean and weighted and non-weighted average score for each composite and rating with comparisons to current Medicaid Adult CAHPS® benchmarks.

3. Key drivers as well as trending analyses of the Statewide composites and ratings may be requested by MDHHS as part of the analytic report. The trending analyses would use data collected from the previous one to two years by MDHHS and/or the MHPs.

4. A report of plan-to-plan comparisons for the demographic and access questions, as well as other selected survey questions, to be determined jointly by the Contractor and MDHHS and illustrated in color graphs/tables/charts.

F. **CSHCS**

1. The Contractor must obtain MDHHS approval prior to mailing a copy of the finalized survey materials (e.g., survey tool, letters, and reminder mailings). The materials must be provided to MDHHS at least 10 business days prior to the start of the data collection phase of the project. The survey tools, letters, and reminder mailings must also be provided in electronic format to the MDHHS Program Manager.

2. The Contractor must produce and share data tables, files and reports with various audiences (e.g. program, health plans, Department, etc.).

    a. The Contractor must produce one electronic copy of the cross-table reports which must include all questionnaire items and the CAHPS® composite variables (indexes/scales). A full frequency distribution of weighted responses for each item is also expected with percentages for valid responses only. Recoded variables must be shown in their final distribution. Summary statistics such as means, standard deviations, and standard errors must also be included for many items and constructed variables.

    b. The Contractor must produce a documenting final disposition of the program's survey. Report items must be presented as program totals and must include the following information:

        i. sample size
        ii. number of surveys mailed
        iii. number of surveys completed
        iv. number of mail returns
        v. number of ineligibles
        vi. telephone follow-up status
        vii. number and status of non-respondents, and
        viii. response rate

    c. A complete set of member level data files must be provided to MDHHS.

    d. The Contractor must provide a full analysis report of the survey findings in the format as defined by MDHHS. The narrative must report the applicable composite measures and global ratings reported as Statewide and regional averages. Regions will be defined by MDHHS. Color tables/graphs/charts must be utilized to report the data.

G. **HKD and FFS Dental and CSHCS HKD populations**

1. The Contractor must submit a copy of the finalized survey materials (e.g. survey tools, letters and reminder mailings) as approved by MDHHS. Each of the participating Dental Health Plans will receive a copy of the materials being sent to their members. All of these materials must be provided to MDHHS and Dental Health Plans at least 10 business days prior to the start of the data collection phase of the project. The survey tools, letters, and reminder mailings must also be provided in electronic format to the MDHHS Program Manager.

2. The Contractor must produce and share data tables, files and reports with various audiences (e.g. program, health plans, Department, etc.).
    a. The Contractor must produce one electronic copy of the cross table reports for each plan and program, including all questionnaire items and the CAHPS® composite variables (indexes/scales) displayed by respondent demographic results (e.g., age, sex, time in plan, overall satisfaction, health status) for all choices for all questions, shown in their final

distribution. Summary statistics such as means, standard deviations, and standard errors must also be included for many items and constructed variables.

b. The Contractor must produce a report documenting final disposition of each plan. The report items must be presented as program totals and by individual Dental Health Plan and must include the following information:

i. sample size(s)
ii. number of surveys mailed
iii. number of surveys completed
iv. number of mail returns
v. number of ineligibles
vi. telephone follow-up status
vii. number and status of non-respondents
viii. response rate

c. The Contractor must provide a complete set of member and summary level data files each participating Dental Health Plan and to MDHHS.

3. The Contractor must produce full analysis reports of the HKD and FFS child survey findings. The Contractor must follow HEDIS®/CAHPS® methodology as described in the most current HEDIS® Specifications for Survey Measures, Volume 3, and subsequent versions, utilizing statistical analysis to detect differences at a 95% confidence level. At a minimum, the full analysis report must include the following:
   a. An executive summary outlining the history/background of the CAHPS® survey, as applicable, and a detailed description of the key findings on a Statewide and plan-to-plan basis, e.g. demographic and survey responses.
   b. Plan-to-plan and FFS comparisons for each of the composite scores and ratings questions to include the Statewide overall average score for each composite and rating. A comparison to current Medicaid Child Dental Plan CAHPS® benchmarks will be requested for the HKD Dental Plan survey, if available.
   c. Trending analyses of the composites and ratings using CAHPS® data collected from the previous years by MDHHS.
   d. A report of Dental Health Plan plan-to-plan and FFS comparisons for selected survey questions, to be determined jointly by the Contractor and MDHHS, illustrated in color graphs/tables/charts

H. **ICO: (Adult CAHPS survey and Adult CAHPS HCBS survey)**

1. The Contractor must obtain MDHHS approval prior to mailing a copy of the finalized survey materials (e.g., survey tool, letters, and reminder mailings). The materials must be provided to MDHHS at least 10 business days prior to the start of the data collection phase of the project. The survey tools, letters, and reminder mailings must also be provided in electronic format to the MDHHS Program Manager.

2. The Contractor must produce and share data tables, files and reports with various audiences (e.g. program, health plans, Department, etc.).

   e. The Contractor must produce one electronic copy of the cross-table reports which must include all questionnaire items and the CAHPS® composite variables (indexes/scales). A full frequency distribution of weighted responses for each item is also expected with percentages for valid responses only. Recoded variables must be shown in their final distribution. Summary statistics such as means, standard deviations, and standard errors must also be included for many items and constructed variables.

f. The Contractor must produce a documenting final disposition of the program's survey. Report items must be presented as program totals and must include the following information:

ix. sample size
x. number of surveys mailed
xi. number of surveys completed
xii. number of mail returns
xiii. number of ineligibles
xiv. telephone follow-up status
xv. number and status of non-respondents, and
xvi. response rate

g. A complete set of member level data files must be provided to MDHHS.

h. The Contractor must provide a full analysis report of the survey findings in the format as defined by MDHHS. The narrative must report the applicable composite measures and global ratings reported as Statewide and regional averages. Regions will be defined by MDHHS. Color tables/graphs/charts must be utilized to report the data.

4.2. Project Plan

A. The Contractor must develop and produce annual work plans for each identified task, to include the proposed completion date and parties responsible for the tasks, that will be drafted and provided to the State's Program Manager for comments and approvals prior to implementation of the work plan; this will include a comments and approval sequence for all templates to be used during the course of the annual task.

Any variations from the approved plans (mentioned above) must be approved by both parties, and the Contractor must propose the remedy and the new deadline date, if applicable.

B. The Contractor must carry out this project under the direction and control of the Program Manager. Within five calendar days of the Contract start date, the Contractor must submit a final work plan to the Program Manager for approval.

Contractor's Plan:

Project Management Skills and Expertise

The Contractor will assign a project director to manage the EQR contract and associated activities according to the State-approved work plan to ensure that activities, tasks, and deliverables remain on schedule and any threat to the schedule can be mitigated in advance to avoid delays. The Contractor will fully support the EQR project directors to acquire the staffing and resources needed to ensure an efficient, successful, and sustainable EQR program throughout the life of the contract. The Contractor will provide training to its project directors, project managers, and activity leaders in the methods of project management from project implementation through project completion.

Staff Training

For new hires, all supervisors provide in-depth education on the responsibilities of a new employee's role within the project team. The Contractor will provide online, one-on-one, and classroom training to accommodate all learning styles. Employees shadow peers to see job roles in action before beginning work on assigned activities. To provide adequate training for the project staff and continuity for all projects, the Contractor will use a skills/competency checklist to ensure individuals possess the necessary skills and competency for the assigned work. Management uses the checklist to assist in providing necessary competency-based orientation, training, and cross-training for the project staff. Supervisors schedule 30-, 60-, and 90-day check-ins with each new staff member to ensure the employee is comfortable in his or her role. Issues with performance, both positive and those needing course correction, are discussed during the check-ins.

To provide training specific to EQR activities, the Contractor will maintain an EQR Operational Policies and Procedures Manual that describes the methods the Contractor staff members follow when conducting each mandatory and optional EQR task. The manual serves as a guide to assist the Contractor staff members conduct all aspects of operations for all EQR activities. The manual also has served as an educational tool for State staff members to become familiar with the EQR tasks the Contractor will perform during the EQR services contract. While its core procedures are based on the required CMS protocols for EQR activities, the Contractor will customize its approach, review tools, and reports to be responsive to an individual state's EQRO contract requirements as well as needs and preferences of the state and its stakeholders. The manual also includes example review tools for the mandatory EQR activities.

Project Director Experience

The EQR Project Director for Michigan will provide oversight for the development of all project deliverables and will be responsible for the quality of all work performed by the project staff, which will include performance improvement project (PIP) validation, review of compliance with State and federal standards, network adequacy validation, CAHPS surveys, and performance measure validation and HEDIS analysis, and consumer guide development.

Project Manager Experience

The Project Manager will be responsible for managing activity timelines to ensure project deliverables are submitted to MDHHS on time and in accordance with the scope of work. In addition, the Project Manager will manage audit review tool development, desktop review processes, and report production for compliance reviews. The Project Manager will lead compliance audits and serve as the clinical liaison for the compliance review team. The Project Manager will draft technical reports, compliance audit deliverables, focused study methodologies, and other EQR reports as needed for the contract.

Contractor's Proposed Project Management Approach:

Project Management Approach

The Contractor's project management approach to execute the annual work plan for each EQR task involves a staffing structure that supports project oversight, management of activities and timelines, and regular communication with MDHHS. The Contractor's corporate infrastructure provides expertise and support to the EQR project directors and activity leaders. The Contractor has found that ensuring the ongoing success of annual EQR activities starts with a staffing structure that supports the project director to effectively:

- Plan upcoming projects and communicate with MDHHS.
- Oversee developing and maintaining the EQR methodology and data collection tools.
- Communicate with MCOs and distribute guidance and data collection tools to them.
- Collect MCO information and data to complete each EQR activity.
- Oversee the completion of each EQR activity, to include analyzing and compiling findings.
- Submit draft EQR reports to MDHHS for review and input.
- Finalize approved EQR reports to submit to MDHHS and distribute to MCOs.
- Respond to MCO questions and conduct technical assistance and training with MCOs, as requested.
- Annually evaluate and summarize the EQR activities of the previous year and recommend improvements for future years.

The Contractor's EQR Management Plan and Oversight

The Project Director will be responsible and accountable for the project's success and MDHHS' satisfaction. Under the Project Director direction, task teams and the Project Manager will function to fulfill the requirements of the MDHHS EQR contract, including all EQR activities, weekly meetings, reporting, and communications with MDHHS and the MCOs. Each activity leader will serve as a subject-matter expert and will work jointly with the Project Director to provide MDHHS with EQR support, as requested.

Each activity leader will be accountable for the work of each functional area's team and will report the status of each task to the project director. The Contractor's activity leaders will provide MDHHS expert advice on Medicaid managed care issues, policies, and national best practices related to the EQR activities they perform. Jointly, the Project Director and the activity leaders will present MDHHS with proactive ideas and suggestions for enhancements, as needed, for problem-solving.

Communication With MDHHS

The Contractor will provide forums such as teleconferences, webinars, or face-to-face meetings to communicate the status of EQR activities with MDHHS' staff members. In addition to working directly with the Project Director,

MDHHS staff members also will have direct access to each EQR activity leader and will be encouraged to maintain direct, regular communication with activity leaders for the duration of the activity. Similarly, the Contractor's activity leaders may contact MDHHS' staff members to discuss the status of data transfer or other information that might be necessary to complete the activity. The Contractor anticipates that, at a minimum, the following types of meetings will occur:

- **Kick-off meeting**—At a time agreed to by MDHHS, the Contractor will hold a kick-off meeting with MDHHS staff members. The Contractor will introduce its Project Director, Project Manager, and EQR activity leaders to MDHHS staff members at this meeting and will discuss the project objectives, annual work plan, timelines, and the EQR strategy for each task scheduled for the first year of the contract. The kick-off meeting also will enable the Contractor staff members to clarify MDHHS expectations for each deliverable, gain knowledge regarding the initiatives in progress, obtain MDHHS' input for initial and ongoing EQR project timelines and deliverables for the first EQR contract year, and finalize the annual work plan.
- **Biweekly progress meeting**—The Contractor's Project Director will facilitate biweekly progress meetings between MDHHS staff members and, as needed, the EQR activity leaders. The biweekly progress meetings will review the status of each EQR activity detailed in the MDHHS-approved annual work plan, discuss milestones associated with each activity, and discuss the challenges and accomplishments of the prior period in addition to outstanding issues that have the potential to impact the timeline. The progress meeting will allow the MDHHS program manager and MDHHS staff members the opportunity to influence decisions regarding critical milestones, provide guidance on ongoing activities, and help resolve issues that may impact an activity.
- **Biweekly progress report**—The Contractor will prepare and submit to MDHHS a biweekly progress report that will include the status of major activities and tasks in relation to the MDHHS-approved EQR work plan. The progress report will provide a status for each activity since the prior period, a status update and target completion dates for remaining and upcoming tasks and activities, and challenges and accomplishments since the prior period. If the need arises to revise the overall work schedule, the Contractor Project Director will discuss the need with MDHHS and seek approval for a revision.
- **Annual EQR update meeting**—In the fall of each contract year, the Contractor will conduct an annual update for the MHPs, including other MCOs as requested, as well as the MDHHS key personnel. This face-to-face meeting will allow the Contractor staff members to summarize the activities from the prior year and discuss activities planned for the following year.
- **Ad hoc meetings and technical assistance**—To discuss MDHHS' comments resulting from review of draft EQR reports or clarify the objectives of any activity that MDHHS requests, such as technical assistance for MDHHS or MCO staff members, the Contractor will facilitate ad hoc meetings with the MDHHS staff. For technical assistance requests related to a specific EQR activity, the project director will forward the information to the EQR activity leader, who will meet with MDHHS staff members to clarify expectations and develop appropriate training materials required for the training.

Meeting EQRO Deadlines as Specified by CMS

The Contractor will prepare and submit annual work plans for each task detailed in the scope of work. Within five calendar days of the contract start date, the Contractor will submit the final annual work plan to MDHHS for approval before implementing the work plan. The annual work plan will include each activity, the sequence and timing of the activity and its defined subtasks, the proposed submission dates for the deliverables (draft and final), and the individuals and teams responsible for the activity. The annual work plan will be the primary tool to manage the MDHHS EQR contract. The Project Director will monitor the plan and update it as needed. After the first contract year, the Contractor will submit the work plan annually within the time frame that MDHHS requires. The annual work plan will function as a "roadmap" that delineates each task, inclusive of milestones, deliverables, responsible personnel, and task completion dates for both the Contractor and MDHHS to follow throughout the EQR contract. Each work plan will be planned to ensure that the Contractor delivers final reports before March 31 so MDHHS can meet the April 30 CMS deadline for posting final reports.

a. Project Timeline

The following timeline example includes the tasks and proposed completion dates for the annual EQR technical reports. This timeline will serve as the basis to complete each technical report timeline to ensure that the Contractor delivers the MHP, DHP, and ICO final reports to MDHHS by March 31 each year so MDHHS can meet the annual April 30 deadline for posting the final EQR technical reports and submitting them to CMS. The Contractor will be prepared to submit, for MDHHS review and approval and within five calendar days of the contract start date, a detailed EQR work plan that includes the specific tasks and proposed due dates for producing each required EQR technical report. The Contractor will modify the schedule according to MDHHS specifications and needs.

EQR Technical Report Work Plan	Responsible Party	Proposed Date(s)
Contract Year 1		
Project Initiation		
Submit draft EQR technical report work plan to MDHHS for review and approval	The Contractor	10/01/19–10/06/19
Submit comments on draft work plan to the Contractor	MDHHS	11/08/19
Finalize work plan and submit to MDHHS for approval	The Contractor	11/15/19
Submit draft EQR technical report outline to MDHHS for review and approval	The Contractor	07/01/20
Submit draft EQR technical report outline feedback to The Contractor	MDHHS	07/15/20
Incorporate MDHHS feedback into outline and finalize	The Contractor	07/22/20
Report Analysis (Example only; data for each report will vary by MCO type)		
Data available from CAHPS survey—Child	The Contractor	08/10/20
Data available from Consumer Guide	The Contractor	08/13/20
Data available from CAHPS survey—Adult	The Contractor	09/04/20
Data available from performance measure validation (analysis of HEDIS, other data sources)—Aggregate Report	The Contractor	09/15/20
Data available from performance improvement project (PIP) validation and technical assistance	The Contractor	09/30/20
Data available from network adequacy validation including Secret Shopper Calls	The Contractor	09/30/20
Data available from review of compliance with access, structural, and operations standards	MDHHS/The Contractor	11/01/20
Aggregate and analyze data from EQR activities and prepare draft report	The Contractor	11/01/20–02/06/21
Report Preparation		
Submit draft report to MDHHS for review and approval	The Contractor	02/07/21
Provide feedback to The Contractor on the draft report	MDHHS	03/10/21
Incorporate MDHHS feedback and develop final report	The Contractor	03/11/21–03/16/21
Submit final 508-compliant report to MDHHS	The Contractor	03/17/21

4.3. Meetings

The Contractor must attend the following meetings:

A. The Contractor must conduct bi-weekly (every two weeks) conference calls with MDHHS, and produce a progress report, detailing the challenges and accomplishments of the prior period that is sent via email to the Program Manager.

B. The Contractor should also be available to conduct an annual update for the MHPs and the State's key personnel, typically requested in the fall of the year. The Contractor should also be available to conduct face to face meetings, two times a year, in Lansing, MI.

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

4.4. Reporting

The Contractor must submit the following written reports to MDHHS:

A. **Biweekly Progress Report:** The Contractor must submit written bi-weekly summaries of progress which outline the work accomplished during the reporting period; work to be accomplished during the subsequent reporting period; problems, real or anticipated, which should be brought to the attention of the Department's Program Manager; and notification of any significant deviation from previously agreed-upon work plans. MDHHS and the Contractor will mutually agree to the timing of the delivery of these reports. These reports must be submitted in either an electronic and/or hard copy format as mutually agreed upon by MDHHS and the Contractor, to the attention of the Department Program Manager.

B. **CAHPS update:** In addition, during the survey implementation phase of the Contract, the Contractor must submit a bi-weekly survey production status report for the MHP (adult and child), FFS (adult and child), and CSHCS samples, HMP, HMP Dental, HKD and ICO as applicable. All bi-weekly status reports must contain total survey and individual plan and/or program results by population (adult and child), as applicable. The reports must include the following information, at a minimum:

1. Number of surveys mailed
2. Number of mail returns
3. Number of completed surveys received
4. Number of ineligibles
5. Telephone follow-up status (numbers loaded and call outcomes), as applicable
6. Number and status of non-respondents
7. Up-to-date response rate

These reports may be submitted in either an electronic or hard copy format as mutually agreed upon by MDHHS and the Contractor, to the attention of the Department's Program Manager.

C. **Technical Report:** The contractor must produce in a timeframe and manner agreed by both parties, which includes, but not limited to, the following:

1. To provide MDHHS with an objective and comprehensive analysis of each MHP's and Dental Health Plan's and ICO's strengths and weaknesses in regard to quality outcomes, timeliness of, and access to the services. The analysis performed will evaluate each fiscal year (October-September) activities including performance measures reported by the MHP or Dental Health Plan and ICO's compliance with specific regulating and contracted requirements.
2. The analysis, in a report format, must evaluate the MHP's or Dental Health Plan's and ICO's performance, provide comparisons to the MHP's or Dental Health Plan's or ICO's previous evaluation (in subsequent years of the Contract should it be renewed), and provide recommendations to MDHHS and the MHP or Dental Health Plans or ICO's on performance improvement opportunities; by using comparative information about all MHPs or Dental Health Plans and ICO's as determined by MDHHS and as methodologically appropriate, including, but not limited to the most current NCQA Quality Compass Report.
3. An assessment of the degree to which each MHP or Dental Health Plan and ICO's has addressed effectively the recommendations for quality improvement made during the previous year's review.
4. The Contractor must collate and disseminate to MDHHS and the MHPs or Dental Health Plan's and ICO's information collected during the EQR related activities concerning best practices and improvement strategies that have demonstrated success (clinical and administrative).

D. **PIP Report:** The Contractor must produce a PIP Report. The MHP PIPs must be designed, conducted and reported in a methodologically sound manner. A completed PIP includes a baseline measurement and two re-measurements. MDHHS will require MHPs to complete a PIP by the end of the fiscal year; the PIP study will be validated at the end of the calendar year.

The Dental Health Plan's PIPs must be designed, conducted and reported in a methodologically sound manner. A completed PIP includes a baseline measurement and two re-measurements. MDHHS will require Dental Health Plans to complete a PIP by the end of the fiscal year; the PIP study will be validated at the end of the calendar year.

The ICO's PIPs must be designed, conducted and reported in a methodologically sound manner. A completed PIP includes a baseline measurement and two re-measurements. MDHHS will require Plans to

complete a PIP by the end of the fiscal year; the PIP study will be validated at the end of the calendar year.

The Contractor must:

1. Produce a detailed, health plan specific, technical report, of the validity of the PIP for each MHP or Dental Health Plan or ICO plan using protocol consistent with the CMS EQR Protocol on Validating PIP's.
2. Work with MHPs or Dental Health Plans or ICO plan to evaluate and validate the MHP's or Dental Health Plan's, or ICO's PIP. This task may require the Contractor to make presentations to the health plans or conduct technical assistance conference calls to the health plans, as needed.
3. The Contractor must provide MDHHS with a summary report of the validation findings of each MHP or Dental Health Plan or ICO plan.

E. Statewide Report and Inhouse Report: HEDIS® Analysis

The CMS EQR protocols require states to evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, an MHP or Dental Health Plan and determine the extent to which Medicaid-specific performance by an MHP or Dental Health Plan followed state specifications. As part of the MDHHS annual reporting requirements, MHPs and Dental Health Plan must submit copies of the audited Medicaid HEDIS® IDSS and Final Audit report. An aggregate assessment of HEDIS® data is used by MDHHS to annually evaluate MHP's and Dental Health Plan's performance levels.

The Contractor must:

1. Comparatively review MHP or Dental Health Plan quality of care outcomes and performance measures and utilize the findings as part of this task to meet the require EQR protocol.
2. Have access to and utilize the most current NCQA Medicaid benchmarks in order to appropriately address aspects of the MHP's or Dental Health Plan's performance.
3. Produce an in-house report and Statewide aggregate report of State selected Quality measures.

F. Strategic Report on Consumer-Related Surveys:

MDHHS requires each MHP to perform a consumer satisfaction survey of Medicaid managed care adult enrollees. The results of the survey will be made available to the Contractor to provide a comparative analysis of the MHP CAHPS® data to support the development of the Michigan Medicaid Consumer Information Guide and include findings in the technical report. The analysis helps to support MDHHS public reporting of health plan performance information.

MDHHS requires each Dental Health Plan to perform a consumer satisfaction survey of Medicaid managed care HDK program enrollees. The results of the survey will be made available to the Contractor to provide a comparative analysis of the Dental Health Plan's CAHPS® data to develop a Quality Rating System to support the development of the Michigan Medicaid Consumer Information Guide for HKD and include findings in the technical report. The analysis helps to support MDHHS public reporting of dental health plan performance

5. Pricing

5.1. Price Term

Pricing is firm for the entire length of the Contract.

5.2. Price Changes

Adjustments will be based on changes in actual Contractor costs. Any request must be supported by written evidence documenting the change in costs. The State may consider sources, such as the Consumer Price Index; Producer Price Index; other pricing indices as needed; economic and industry data; manufacturer or supplier letters noting the increase in pricing; and any other data the State deems relevant.

Following the presentation of supporting documentation, both parties will have 30 days to review the information and prepare a written response. If the review reveals no need for modifications, pricing will remain unchanged unless mutually agreed to by the parties. If the review reveals that changes are needed, both parties will negotiate such changes, for no longer than 30 days, unless extended by mutual agreement.

The Contractor remains responsible for Contract Activities at the current price for all orders received before the mutual execution of a Change Notice indicating the start date of the new Pricing Period.

6. Ordering

6.1. Authorizing Document

The appropriate authorizing documents for the Contract will be a signed Master Agreement as well as an Agency Issued Delivery Order (DO).

7. Invoice and Payment

7.1. Invoice Requirements

All invoices submitted to the State must include: (a) date; (b) delivery order; (c) quantity; (d) description of the Contract Activities; (e) unit price; (f) shipping cost (if any); and (g) total price. Overtime, holiday pay, and travel expenses will not be paid.

Each task/deliverable described herein, may be invoiced for payment when the final task/deliverable is completed.

The EQRO Technical Report is the only exception, which may be invoiced at 40% of full invoice at the completion of an acceptable draft version, and the balance of 60% at the delivery of the final version.

7.2. Payment Methods

The State will make payment for Contract Activities via Electronic Funds Transfer (EFT).

8. Liquidated Damages

Late or improper completion of the Contract Activities will cause loss and damage to the State and it would be impracticable and extremely difficult to fix the actual damage sustained by the State. Therefore, if there is late or improper completion of the Contract Activities the State is entitled to collect liquidated damages in the amount of $5,000 and an additional $100 per day for each day Contractor fails to remedy the late or improper completion of the Work.

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization Services for Prepaid Inpatient Health Plans – Michigan Department of Health and Human Services

SCHEDULE A.2
STATEMENT OF WORK
CONTRACT ACTIVITIES

BACKGROUND

In Michigan, since 2002, prepaid inpatient health plans (PIHPs) have been "carved out" from the State's Medicaid Health Plans (MHPs) to manage the specialty services benefit for persons with a mental illness, developmental disability, or addictive disorder – the only waiver program in the country authorized by the Centers for Medicare and Medicaid Services to serve all three populations. The PIHPs are comprised of single or multiple community mental health services programs (CMHSPs). They are funded on a shared-risk, per member per month, capitated basis with federal and state Medicaid dollars. This system serves approximately 294,016 consumers during the fiscal year, approximately 88 percent of whom are Medicaid eligible.

Key changes for 2019. The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services in Michigan. This initiative is based upon Section 298 in the Public Act 268 of 2016. Under Section 298, the Michigan Legislature directs the Michigan Department of Health and Human Services to develop a set of recommendations "regarding the most effective financing model and policies for behavioral health services in order to improve the coordination of behavioral and physical health services for individuals with mental illnesses, intellectual and developmental disabilities, and substance use disorders." The Michigan legislature approved a revised version of Section 298 as part of Public Act 207 of 2018. Under the revised Section 298, the Michigan legislature directed the department to develop and implement up to three pilots and one demonstration model to test the integration of physical health and behavioral health services. Three pilot sites have been identified:

- Pilot #1: Muskegon County CMH (dba HealthWest) and West Michigan Community Mental Health
- Pilot#2: Genesee Health System
- Pilot #3: Saginaw County Community Mental Health Authority

The Section 298 Pilot might also require an additional PIHP to be formed to serve Medicaid beneficiaries who are not enrolled in a Medicaid Health Plan.

To view further progress and detailed actions plans, visit www.michigan.gov/stakeholder298

In April 2014, Michigan implemented the Healthy Michigan Plan (aka Medicaid expansion). The Healthy Michigan Plan is a health care program that is administered by the Michigan Department of Health and Human Services, Medical Services Administration. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. The program was implemented as authorized under the Affordable Care Act of 2010 as codified under 1902(a)(10)(A)(i)(VIII) of the Social Security Act and in compliance with the Michigan Public Act 107 of 2013.

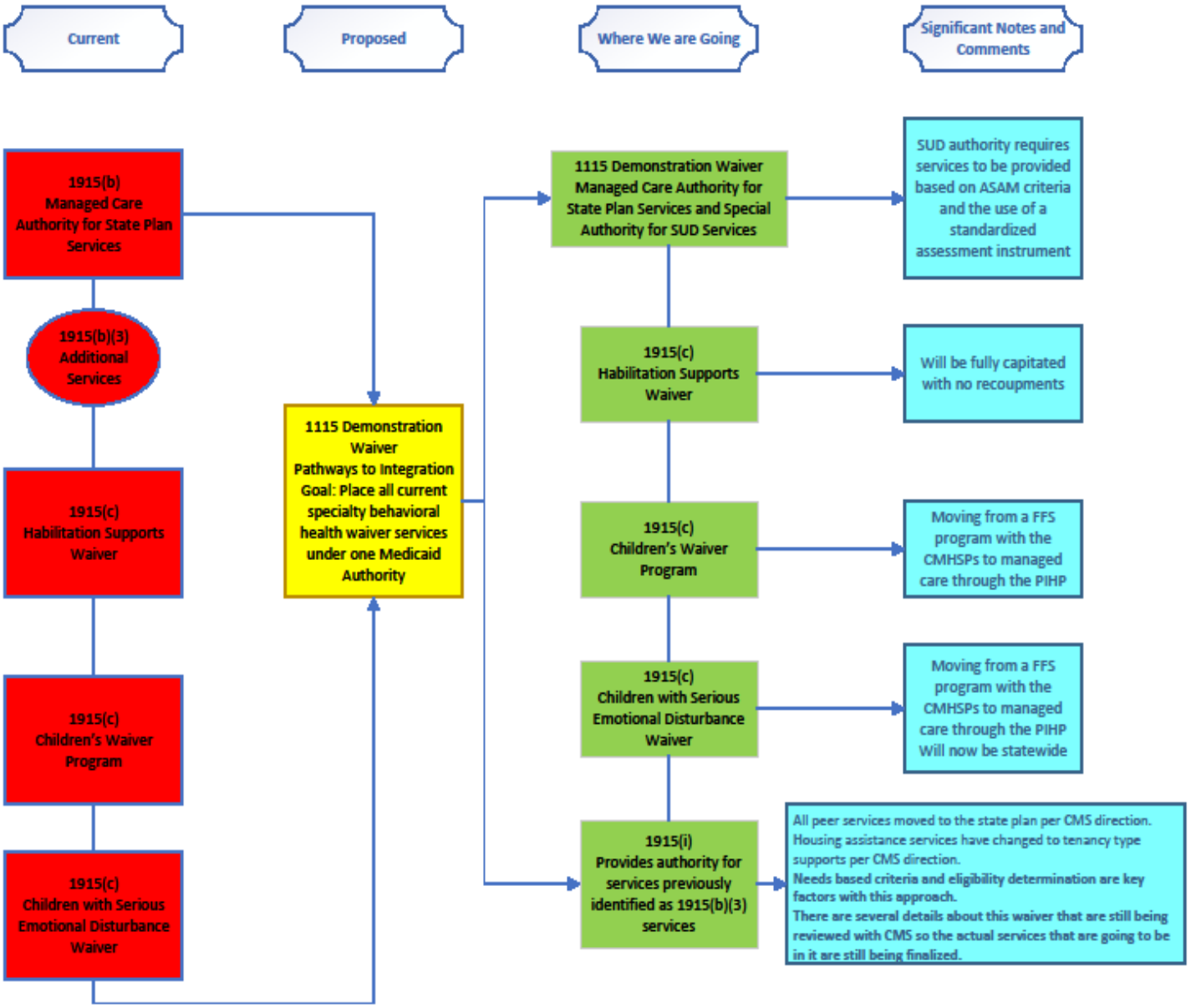
The Healthy Michigan Plan provides health care coverage for individuals who:

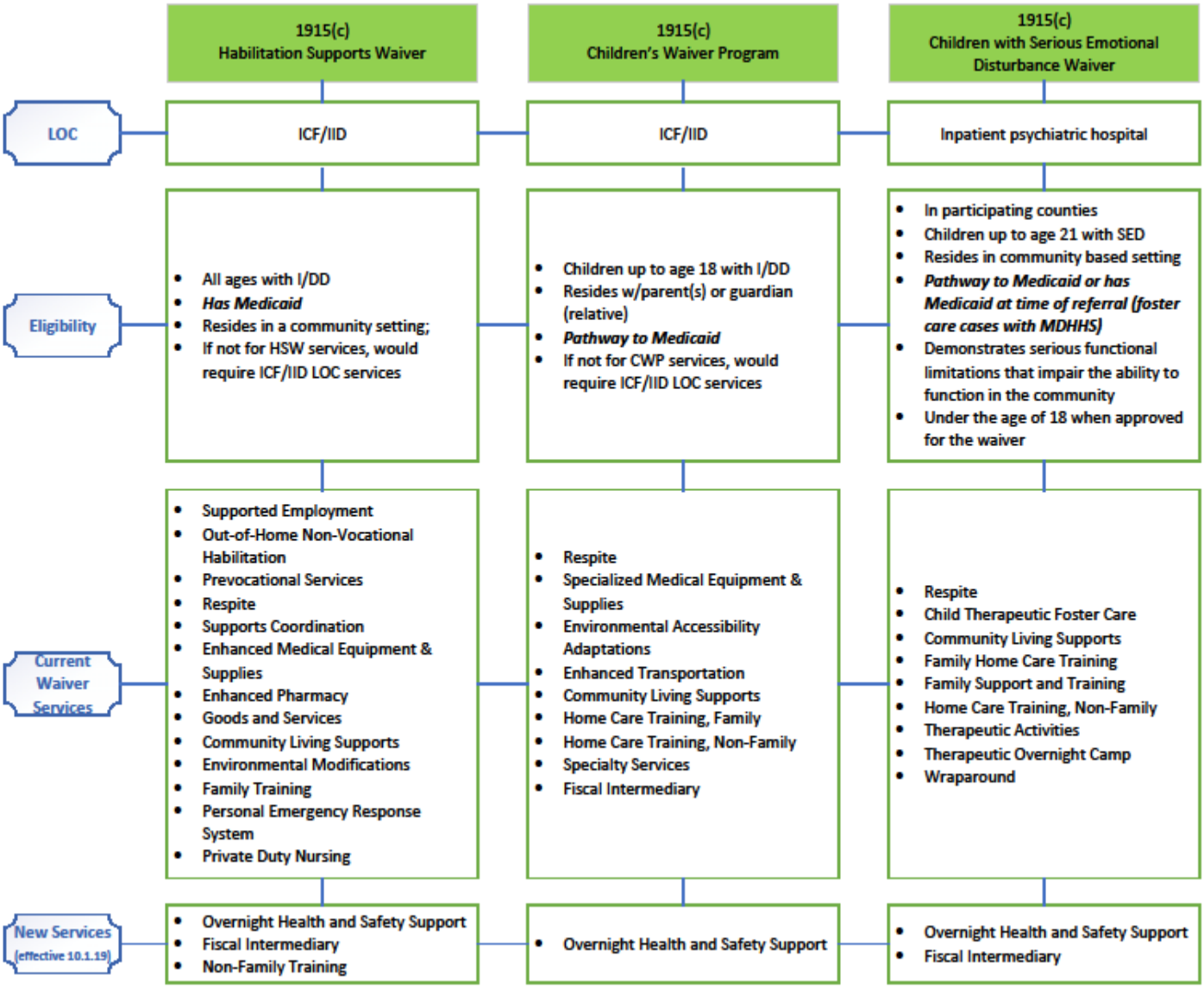
- Are age 19-64 years
- Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology

- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

In 2014, the PIHPs were re-procured based on 10, new regional boundaries drawn by MDHHS. The key objective of these 10 new entities was to consolidate CMHSP authority and core functions, while simultaneously promoting local responsiveness. Also, in 2014, the Substance Abuse Coordination function was fully merged within the CMHSP system (Michigan P.A. 500 & 501).

Key changes for 2020. MDHHS has been working with the Centers for Medicaid and Medicare Services to take advantage of new Medicaid authorities for the provision of specialty behavioral health services. The schematic below shows the current authorities for 2019 and anticipated array of authorities that will be in place as early as October 1, 2019.


Current
Proposed
Where We are Going
Significant Notes and Comments
1915(b) Managed Care Authority for State Plan Services
1915(b)(3) Additional Services
1915(c) Habilitation Supports Waiver
1915(c) Children's Waiver Program
1915(c) Children with Serious Emotional Disturbance Waiver
1115 Demonstration Waiver Pathways to Integration Goal: Place all current specialty behavioral health waiver services under one Medicaid Authority
1115 Demonstration Waiver Managed Care Authority for State Plan Services and Special Authority for SUD Services
1915(c) Habilitation Supports Waiver
1915(c) Children's Waiver Program
1915(c) Children with Serious Emotional Disturbance Waiver
1915(i) Provides authority for services previously identified as 1915(b)(3) services
SUD authority requires services to be provided based on ASAM criteria and the use of a standardized assessment instrument
Will be fully capitated with no recoupments
Moving from a FFS program with the CMHSPs to managed care through the PIHP
Moving from a FFS program with the CMHSPs to managed care through the PIHP Will now be statewide
All peer services moved to the state plan per CMS direction.
Housing assistance services have changed to tenancy type supports per CMS direction.
Needs based criteria and eligibility determination are key factors with this approach.
There are several details about this waiver that are still being reviewed with CMS so the actual services that are going to be in it are still being finalized.



Section 1932(c) of the Balanced Budget Act of 1997 (BBA) requires external review of Medicaid Managed Care Organizations. In the final rule to implement this provision, the Department's Centers for Medicare & Medicaid Services (CMS) also required annual, independent, external review of prepaid inpatient health plans (PIHPs). The BBA §438.358 outlines the required and optional activities related to the external quality review. The BBA directed the Department of Health and Human Services (DHHS) to contract with an independent quality review organization to develop protocols to be used for the nine external review activities. These protocols are located on the Web at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. DHHS requires external quality review activities to be consistent with these protocols. Three of the activities are mandatory for PIHPs and are the focus of this RFP – assessment of compliance with federal managed care regulations, validation of performance measures, and validation of performance improvement projects. This RFP also includes the optional activity – Administration or Validation of consumer or provider surveys of quality of care.

SCOPE

General Objectives for the Contractor for the Behavioral Health and Developmental Disability Administration (BHDDA) component:

1) Planning for compliance monitoring activities and collecting contact information on the PIHP.
2) Obtaining background information from the State Medicaid Agency in regard to State specified regulatory standards in response to the BBA. As provisions of the final regulations required or allowed the State Medicaid Agency to specify certain standards or requirements for MCOs/PIHPs, the EQRO will need to obtain from the State Medicaid Agency any state-specified standards, requirements, or decisions pertaining to PIHP regulations.
3) Document review
4) Conducting interviews with PIHP personnel
5) Collecting any other accessory information; e.g. from site visits
6) Analyzing and compiling findings
7) Reporting results to the State Medicaid Agency

Specific Objectives for the BHDDA component:

(1) Develop an overall plan
(2) Conduct Activity to Determine Compliance with Medicaid Managed Care Proposed Regulations
(3) Conduct Activity to Validate Performance Measures
(4) Validating Performance Improvement Projects
(5) Optional Activity

REQUIREMENTS

1. General Requirements

1.1. Work and Deliverables

Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

A. **An overall plan must be developed as a basis for executing the contract.**
Essential to the process of this task is the preparation of a sound approach to attaining the objectives of the contract. MDHHS approval is required before the implementation of any plan.

B. **Conduct Activity to Determine Compliance with Medicaid Managed Care Proposed Regulations**

The Balanced Budget Act of 1997 (BBA) includes section 1932 to the Social Security Act that sets quality standards for Medicaid managed care plans. Most of the provisions of section 1932 of the Act are implemented in accordance with the Medicaid managed care final rule that was published in the Federal Register on May 2016 (67 CFR 0988) and updated through 42 CFR 438. The key external review activity of this RFP is determination of PIHPs compliance with the Federal quality standards as specified by the State. This focus is to include determination of PIHP compliance to the regulations in respect to quality, timeliness and access for consumers served by the Community Mental Health system.

The CMS protocol describes the following steps required for this review: Review

1. Obtain background information from the State Medicaid agency in regard to State-specified regulatory standards in response to the BBA. As provisions of the final regulations required or allowed the State Medicaid agency to specify certain standards or requirements for MCOs/PIHPs, the Contractor must obtain from the State Medicaid agency any state-specified standards, requirements, or decisions pertaining to PIHP regulations.
2. Define levels of compliance.
3. Establish early contact with the PIHP.
4. Perform a preliminary document review.
5. Determine onsite interview logistics – length of visits, dates, number and types of reviewers needed.
6. Establish an agenda for onsite review.
7. Provide preparation instructions and guidance to the PIHP for the onsite review.
8. Conduct onsite document review.
9. Conduct interviews with PIHP personnel.

10. Conduct exit PIHP Interviews.
11. Analyze and compile findings.
12. Report results to the State Medicaid Agency

The central activities are the document review and interviews with PIHP personnel. The CMS protocols describe how to combine and conduct document review and interview activities in order to determine the extent to which a PIHP complies with the BBA regulatory provisions.

The protocol provides an extensive list of suggested documents for review and identifies the regulatory provision(s) each document addresses. The protocol also includes suggested reporting tools for recording findings from the document reviews. The State is required as part of the EQR process to review as many documents necessary to determine compliance/noncompliance by a PIHP for a particular regulation. One of the initial tasks of this EQR, therefore, must be to determine the minimal set of documents available in Michigan that will provide the required compliance information.

While document review is an important part of determining compliance, understanding the document content and performance of procedures outlined in the documents typically can only be determined by talking with PIHP personnel. The protocol requires interviews with PIHP staff to obtain a complete picture of the degree of compliance with requirements. The protocol identifies the following groups for interview:

1. PIHP leadership
2. PIHP information system personnel
3. Quality assessment and performance improvement program personnel
4. Provider and contractor services staff
5. Enrollee services staff
6. Utilization management staff
7. Medical Director
8. Case managers and care coordinators
9. PIHP providers and contractors, as appropriate and as time and resources permit.

The protocol lists suggested participants for each group according to title and/or role. The protocol also lists the issues and questions to be addressed during each set of interviews, which are designed as potential guides for exploration of compliance issues. As with the documents, CMS requires that the review include those individuals who can provide the required information regarding compliance to the Federal regulations. During the initial step of the external review process, the Contractor must work with the State to determine the key individuals to include in the interviews for each PIHP.

The Contractor must work with the State to determine the amount of document review and interview activities that must be conducted onsite at the PIHP. As appropriate, consideration should be given to conducting centralized collection and review of the documentation at the State office via FTP site, and phone conference interviews in order to reduce the cost and time burdens of onsite visits.

In the summary and conclusion steps, the protocol includes numerous options for analyzing and compiling findings. As part of the response to the RFP, the Contractor is to present approaches they have used in analyzing and presenting data that is similar to one of the approaches described in the protocol.

The detailed protocol is available on the Web at:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Contractor's Plan:

The Contractor will use the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (CMS Protocol 1), as a guide to conduct the compliance review activity that will determine each PIHP's compliance with federal regulations and State contract requirements. The Contractor will employ a mixed method to collect the information necessary to determine each PIHP's compliance.

Approach for Collecting Data

The Contractor's methods for data collection include:

- **Desk reviews**, in which the PIHP submits documents, reports, policies, and other written materials to the Contractor via the Contractor's secure file transfer protocol (FTP) site for collecting data used for each PIHP compliance review.
- **On-site interviews**, in which the Contractor's staff members conduct interviews with PIHP staff members at the PIHP's physical office location. PIHP staff members may also present demonstrations of the various information system platforms the PIHP uses to support operations. These may include grievance and appeal processing and tracking, quality review and improvement tracking, and case management, among others. The Contractor's staff members also may conduct case file reviews to determine the PIHP's ability to operationalize the processes found in its policies and verify the processes are compliant with State and federal regulations.
- **Phone conference interviews and webinars**, in which the Contractor's staff members conduct interviews and/or case file reviews with key PIHP staff members via conference call or through a webinar. Webinars enable the PIHP staff members to present system demonstrations, as detailed in the bullet above.

While preparing for the compliance review, the Contractor will work with MDHHS to determine the amount of document review and number of interview activities either on-site at the PIHP or via phone conference in an effort to reduce the burden of compliance review activities on PIHPs. During these discussions with MDHHS staff members, the Contractor will confirm the list of key individuals to include in the interviews for each PIHP. The Contractor's phone conferencing capabilities enable it to host conference calls with dozens of participants, if the need exists. The Contractor proposes a one-day visit at each of the 10 PIHPs' sites. The Contractor proposes using WebEx to conduct file reviews and additional interview sessions, as necessary, to ensure a comprehensive review. This approach is intended to lessen the burden on the PIHPs by reducing the number of days onsite.

The Contractor will present its methods for analyzing and presenting data in the paragraphs that follow:

Approach for Analyzing and Presenting Data

Determining Levels of Compliance

Before initiating compliance reviews, the Contractor will determine with MDHHS the most appropriate method to define levels of compliance and analyze and present data gathered as part of the compliance review activity. The Contractor will use the scoring scale of *Met* and *Not Met,* which indicates the degree to which the PIHP complied with each requirement, and has used a designation of *Not Applicable* (*NA)* when a requirement is not applicable to the PIHP during the period that the Contractor's review covers. The methodology is consistent with CMS Protocol 1, which describes the scoring designations as follows.

Met (value 1.0 point) indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present; or
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met (value: 0 points) indicates noncompliance, defined as:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions; or
- For those provisions with multiple components, key components of the provision could be identified, and any findings of *Not Met* would result in an overall finding of noncompliance regardless of the findings noted for remaining components.

Analyzing Data

To draw conclusions about the quality and timeliness of, and access to, the care and services the PIHP provided to beneficiaries, the Contractor will aggregate and analyze the data resulting from its desk and on-site reviews. The data that the Contractor aggregates and analyzes will include documented findings describing the PIHP's performance in complying with each requirement.

While the federal and State requirements in the compliance review tool are organized into standards, often the findings in one standard may relate to others. To ensure thorough consideration of all findings and consistency in scoring, the Contractor reviewers will discuss their findings at the end of each day and identify areas of commonality and/or discrepancy. The reviewers bring a comprehensive understanding of the federal Medicaid managed care regulations and their applicability to all types of managed care entities, including behavioral health and substance use disorder health plans. Reviewers understand the complexities of complying with regulations and they will work collaboratively with the PIHPs to provide technical guidance and further the PIHP staff members' understanding of the managed care regulations.

The Contractor also will assign a team leader to each on-site review. These team leaders will ensure that team members completely and correctly document their findings and that the findings support the scores assigned to each requirement. If there are discrepancies between reviewers, the team leader will make the final decision on the finding and report the discrepancy and decision to other team leaders and the project director. Team leaders also will confirm with each other that the team members are consistent in their processes, findings, and scores across the teams and across PIHPs. The Contractor will subject each report to a formal validation review for accuracy of scoring and analytic content, and for consistency across reports.

From the scores it assigns each requirement, the Contractor will calculate a total percentage-of-compliance score for each standard included in the review and an overall percentage-of-compliance score across the reviewed standards by summing the weighted values of the scores and dividing the result by the total number of applicable requirements.

The Contractor also will determine areas requiring specific actions that will bring performance into compliance with requirements assigned a score of *Not Met* or *Partially Met*, if that scoring designation is used.

Presenting Data in the Draft and Final Compliance Reports

After compiling the results from the desk review, on-site review, and/or phone conference or webinar, the Contractor will determine the level of compliance with each element using the scoring methodology that MDHHS approves. The Contractor will create a comprehensive compliance report that includes the completed compliance tools it uses for the review. The Contractor will propose a report template that ensures the peer-reviewed, final annual written compliance review report meets MDHHS' expectations for the format, structure, organization, and content. The report template will include the information needed to describe the PIHP's compliance with the standards as well as an explanation of the technical methods of data collection and analysis. At a minimum, the Contractor will include the following information in each PIHP's report:

- Specific findings and recommendations with respect to the PIHP's compliance with federal requirements and MDHHS' contract standards.
- A listing of areas requiring corrective action to bring the PIHP into full compliance with the requirement for each standard scored less than fully met.
- A template the PIHP will use to document its corrective action plans (CAPs) for each element that did not receive a *Met* rating.

The Contractor will submit each PIHP-specific draft report to MDHHS for its review and comment before finalizing the report.

Reviewing Corrective Action Plans

Upon MDHHS' request, the Contractor will evaluate the PIHPs' CAPs for any element not receiving a *Met* score. The Contractor will manage and conduct CAP reviews to assess the sufficiency of proposed interventions/activities and timelines to determine whether these actions can reasonably bring MCOs'/PIHPs' performance into full compliance with the requirements.

The Contractor will conduct a review and document its assessment of each CAP's potential to resolve performance in areas found not fully compliant. As part of its review of the PIHPs' CAPs, the Contractor will assess whether a CAP is sufficient to resolve the identified deficiencies. Specifically, the Contractor will assess the CAP to determine if it:

- Is complete in addressing each required action, assigns responsibility, includes a due date for completion, and specifies the actions the PIHP will take.
- Meets the intent of the requirement.
- Addresses organizational structure, training, and communication needs, as well as monitoring and follow-up activities.
- Can reasonably be anticipated to result in compliance with the requirement.

If the CAP is not sufficient, the Contractor will describe the deficiencies and recommend revisions. The Contractor will provide its findings to MDHHS in a State-approved format for review and comment. After

approval, the Contractor will provide the CAP assessment report to the applicable PIHP. In the second contract year, the proposed compliance review will include a review of the previous year's CAPs and an assessment of the degree to which a PIHP's implementation of CAP activities resulted in compliance. Any areas of continuing noncompliance will result in a required modified CAP. The Contractor will support the corrective action process by providing the PIHPs with guidance and technical assistance, as needed, when developing and implementing their CAPs. The Contractor will provide technical assistance to ensure the PIHP sufficiently addresses the recommendations for improvement and can be expected to reach compliance successfully when it implements the CAP.

C. **Conduct Activity to Validate Performance Measures**

The Michigan Mission-Based Performance Indicator System contains 14 measures to assess the performance of the PIHPs for adult and child Medicaid beneficiaries who have mental illness, a developmental disability or a substance abuse disorder. These 14 indicators were selected by MDHHS, the Quality Improvement Council, and the Contract and approved by the Financial Issues Committee of the Michigan Association of Community Mental Health Boards.

Since the indicators are a measure of performance, deviations from standards (where applicable) and negative statistical outliers may be addressed through contract action. Information from these 14 indicators is published on the MDHHS web site within 90 days of the close of the reporting period, following one opportunity for CMHSPs and PIHPs to make corrections.

MDHHS has created a workgroup to review and redesign the current set of performance indicators in the Michigan Mission-Based Performance Indicator System (MMBPIS). Members from the workgroup are MDHHS staff and representatives from the PIHP and CMHSP's within all 10 Regions. The Behavioral Health and Developmental Disability Administration (BHDDA) and CMS have noted that the results for some of the indicators vary greatly from results from similar HEDIS measures or analyses from the data warehouse. BHDDA and CMS have also stated that the current performance indicators do not facilitate quality improvement. As a result, the performance indicators may be changed or new indicators added moving forward into FY2020.

Where possible, MDHHS will use data from encounters, BH-TEDS demographic information or Medicaid Utilization and Net Cost Reports, and CMHSP Sub-element Cost Reports to calculate the indicators. However, most of the indicators require separate reporting by the PIHPs using the instructions in the Performance Indicator Codebook. The PIHP Reporting Codebooks are available on the Internet at:

http://www.michigan.gov/MDHHS/0,4612,7-132-2941_38765---,00.html

The CMS protocol describes a process for the Contractor to use when validating these performance measures. In general, the Contractor must: 1. Assess the accuracy of performance measures reported by the PIHP; and 2. Determine the extent to which performance measures calculated by the PIHP follow State specifications and reporting requirements.

The protocol provides instruction for the following steps:

1. Defining the scope of the validation. Determine and reviewing Michigan's current technical specifications, reporting templates and instructions.
2. Assessing the integrity of the PIHP Information Systems.
    a. This must include working with Michigan to review, revise and update Michigan's current Information System Capability Assessment Tool (ISCAT).
3. Selecting the measures for detailed review.
4. Conducting initial review of record data collection.
5. Preparing for the PIHP onsite visit
6. Reviewing the information and query systems underlying performance measurement
7. Assessing data integration and control for performance measure calculation.
8. Reviewing performance measure production.

9. Conducting detailed review of selected measures.
10. Determining preliminary validation findings for each measure as well as outstanding items.
11. Assessing accuracy of PIHP's performance measure reporting to the state.
12. Submitting final validation report to the state.

Contractors are directed to the CMS protocol located at:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

Contractor's Plan:

Proposed Approach to Validate Performance Measures

The Contractor's performance measure validation (PMV) team will use the acceptable methods to validate performance measures, following *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (CMS Protocol 2) and NCQA HEDIS Compliance Audit™ methodology.

The Contractor will collaborate with MDHHS to ensure factors such as eligible populations, denominators, numerators, and measurement periods are well-defined and documented in the Performance Indicator Codebook before the calculation of measures.

The Contractor will customize its PMV approach to ensure optimal support of a state Medicaid agency's overall goals and objectives. The Contractor will validate the 14 measures within the Michigan Mission-Based Performance Indicator System to assess the PIHPs' performance for adult and child Medicaid beneficiaries who have a mental illness, a developmental disability, or a substance abuse disorder. When developing the methodology for the PMV activity, the Contractor will include any MDHHS-specific areas of focus.

The Contractor will provide technical assistance, as needed, to the PIHPs and MDHHS related to performance measure reporting, as well as for any PIHP rate-related data issues and proposed resolutions. The Contractor will provide hands-on support if the PIHP encounters issues collecting or reporting performance measure data, and it will assist the PIHP staff members in establishing continuous quality improvement activities that target areas impacting performance.

The Contractor will validate MDHHS-specified performance measure rates that the PIHPs produce as well as those measures the State calculates. The Contractor will work with MDHHS to identify the time frame to conduct the PMV activities of the State-calculated measures as well as the PIHP-calculated measures based on measure data available for review. The Contractor also will verify the methods used to collect performance measure data that represent the PIHPs' performance during the preceding calendar year.

The three major activities associated with PMVs are the pre-on-site, on-site, and post-on-site phases, as described below:

Activity 1: Pre-On-Site Visit Activities

CMS Protocol 2 describes the actions during the pre-on-site activities to prepare both the EQRO and the PIHPs for the on-site portion of the performance measure validation. The Contractor will:

Determine the Measure(s) and Associated Specifications for Validation

The Contractor will work with MDHHS to identify the Michigan-specific performance measures for validation and to clarify measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification) using the standardized measure specifications. The Contractor also will assist in determining the best format to submit the measures.

Prepare the PIHPs and Communicate Expectations

The Contractor will emphasize the validation planning process so deadlines and expectations for deliverables are clearly identified and agreed upon. The Contractor will provide the PIHPs with technical assistance to report all required performance measures in a manner suitable for validation. During the initial PMV kick-off call, the Contractor will introduce the validation team to the PIHPs and clearly define the roles and responsibilities.

Prepare Documentation Request

The Contractor will provide MDHHS, for its review and approval, a draft documentation request letter and an information collection tool appropriate for the audit. The documentation request also will include the Information

Systems Capabilities Assessment Tool (ISCAT), which is included in CMS Protocol 2 and is used for performance measure validation.

The request letter will detail all required PIHP documentation and the associated timelines for completion. Once approved, the Contractor will transmit the documentation request and ISCAT to the PIHP. The Contractor will instruct the PIHP to complete the ISCAT, as described in the CMS protocols, based on the measures being audited. The Contractor will modify the ISCAT, as necessary, to meet the validation requirements.

The ISCAT is the information collection tool that informs the auditor about the PIHP's information management system. It also collects information on data integration and processes used to determine rates for specific measures. The ISCAT, along with supporting documentation accompanying it, collects information about the PIHP's membership and healthcare delivery environment, data collection tools, common data formats, data file layouts, and results of any data validation studies.

A review of the PIHP's ISCAT information will enable the Contractor to prepare for on-site visits and clarify any outstanding issues. The Contractor will provide the PIHP with technical assistance, as needed, to complete the ISCAT and will work to minimize any burden on the PIHP's staff to complete the documentation request. The Contractor has a secure FTP site for the State and the PIHP to transfer data and other documents related to the validation activity.

Review Source Code

In addition to the ISCAT responses, the Contractor will obtain from the PIHP the detailed source code and programming logic used to calculate each measure. The Contractor programmers, assigned according to familiarity and expertise with the programming language the PIHP uses, will conduct a detailed review of each line of code to ensure strict compliance with measure specifications, identify and estimate any potential bias, and identify any necessary corrections.

Assess Integrity of the PIHPs' Information Systems

Completing an information system capabilities assessment is a critical validation task that provides valuable feedback to MDHHS and the PIHP on the integrity of the information system and the completeness and accuracy of the data the system produces. As part of the ISCAT, the Contractor will receive detailed information regarding all data systems that feed into collecting and reporting performance measures, including patient, provider, claims/encounter, and survey data, as well as data integration processes. The validation team will review submitted documents to identify system or procedural weaknesses that may impact the accuracy of the performance measure rates. The Contractor will review this information before the on-site visit to assist in guiding the team toward specific areas of focus.

Prepare the Agenda for the PIHP On-site Review/Interviews

Performing an efficient and effective on-site review requires an agenda that assists the PIHP with planning staff participation in interviews, gathering required documentation, and addressing logistical issues such as arranging locations for reviewers to conduct documentation review and interviews. An agenda establishes the tone and expectations for the on-site visit, so all participants understand the time frames for the review. The Contractor will send a final agenda to the PIHP no later than two weeks before the visit and will conduct ongoing dialogue so the PIHP can prepare adequately for a productive visit. The Contractor's approach is supportive and educational with ongoing correspondence.

Activity 2: On-site Visit Activities

CMS Protocol 2 requires an on-site evaluation for the validation of performance measures. The Contractor will conduct an on-site visit at the PIHP's location as part of the validation activities. The visit will build on the findings from the pre-on-site document review of the information system, the source code review, and the assessment of provided data. The on-site activities will include a review of systems that collect and create measure-related data and of data integration processes and performance calculation methodologies that either the PIHP performs in-house or the PIHP's subcontractor performs. The Contractor's on-site review process will include the following activities, as detailed on the agenda:

Conduct Opening Meeting

The opening meeting will include introductions between the Contractor auditor and the PIHP's key staff members involved in the performance measurement activities. The auditor will explain how he/she will conduct the review and discuss the purpose of the meeting, the required documentation, a discussion of queries to be performed, and the sharing of findings with the PIHP. Additionally, meeting participants will revisit the agenda and discuss logistics.

Review Data Management Processes

The goal of this session is to determine how the PIHP combines the data sources and produces the analytic file to report the selected performance measures. Session participants will review backup documentation on data integration and the Contractor auditor will interview PIHP staff members regarding software products used during data file production, sampling, and measure computation. The Contractor auditor also will review the PIHP's data control and security procedures during this session.

Review Documentation Processes

Documentation review alone generally is insufficient to determine compliance because content and actual performance of procedures in the documents typically can be confirmed only through interviews with the PIHP's personnel. The Contractor auditor will discuss the PIHP's documentation processes to collect, store, validate, and report the performance measure data. This session will be interactive with the PIHP's key staff members so the auditor can obtain a complete picture of all steps that generate the performance measures. The interviews will be used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice. The auditor will take notes throughout the interviews to document the review findings. Types of reviewed documentation will include the project work plan, data files, data dictionaries, testing and validation of output files, computer queries, policies and procedures, log files, and database/application manuals.

Evaluate Algorithmic Compliance

The on-site audit will include a complete information systems assessment that focuses on claims and encounter data, enrollment data, and provider data processing. Additionally, the Contractor auditor will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance. This review will ensure correct rate calculations, appropriate combining of data, and an accurate count of numerator events.

During this session the Contractor auditor will use several review techniques, including staff interviews, primary-source verification, and observation to examine the data collection and reporting processes.

Report Performance Measures

The Contractor will ensure the PIHP has reported the performance measures to MDHHS using the proper reporting tool and delivery method and keeping in mind appropriate timelines. The Contractor will ensure the reporting of all required measures, as MDHHS specifies, and will note any deviations. The Contractor will instruct the PIHP to correct any issues.

Conduct Closing Conference

At the end of the on-site visit, the Contractor will conduct a summation conference with the PIHP's key staff members. This meeting will summarize preliminary findings and outline the documentation and/or corrective action requirements post-site visit.

Activity 3: Post-Site Visit Activities

The focus of the post-site visit includes assessing the PIHP's corrective actions and the medical record review validation process, as follows:

Assess Status of PIHP Corrective Actions

The Contractor will track the verbal and written exchange of information throughout the audit and provide recommendations to improve or correct deficiencies. Further, the Contractor will ensure the resolution of each issue and will record the dates the PIHP corrected the deficiencies and the date the Contractor verified the corrections.

Verification of PIHP Corrections

The Contractor will notify the PIHP of all findings as soon as possible to allow enough time for corrective action, if necessary. Upon resolving all requested follow-up items and any corrective actions, the PIHP will receive a final information system tracking grid that shows the result for each item.

Assessing the Accuracy of Performance Measures the PIHP Reports

The Contractor will review the final rates to assess data completeness and accuracy, comparing the current year's rates to the prior two years' rates (if available) to show performance over time. Any significant increase or decrease in rates will be highlighted with feedback and questions. During final rate review, the Contractor will compare the final rates with the preliminary rates and note any significant changes. If it discovers any errors during preliminary rate review, the Contractor will review the final rates to ensure the errors were corrected.

Determining if Performance Measures Calculated by the PIHP follow State Specification and Reporting Requirements

The Contractor will verify that the PIHPs' final rates follow the MDHHS State Specification and Reporting Requirements as well as if it notes any discrepancies in the PIHP's calculations, incorporating these findings into the report and providing feedback to the PIHP. The auditor will assess the extent to which the audit findings affect reporting and will advise the PIHP that noncompliance may result in designating the measures as Not Reportable (NR). The Contractor will include final measure scoring and any recommendations in the final audit report.

The Contractor will use the standardized rating methodology for PMV, as outlined in the current CMS Protocol 2. The following is a list of the validation findings and their corresponding definitions used in assigning uniform ratings:

- R = Report—The measure was compliant with state specifications.
- NR = Not Reportable—This designation is assigned to measures for which (1) the PIHP rate was materially biased, or (2) the PIHP was not required to report.
- NB = No Benefit—The measure was not reported because the PIHP did not offer the benefit the measure required.

The Contractor lead auditor will ensure that the PMV team members accurately document their findings and that findings support the rate designations assigned to the measures. Lead auditors will confer with each other and debrief after each audit to confirm that each review is consistent in processes, findings, and scores across the various audit team members. The Contractor also will subject each audit conclusion to a peer review validation process that will review for consistency and accuracy of scoring and analytic content.

Report Findings

The Contractor will send the PIHP-specific draft report of findings from each PMV to MDHHS for review and approval. Upon MDHHS' approval, the Contractor will provide each PIHP its preliminary findings in a draft PMV report, which will incorporate audit findings from the pre-on-site, on-site, and post-site visit activities. The report will consist of a description of the audit process and methodology, a review of standards and data sources, and recommendations for data collection and analysis. The measure validation section will include methods used to obtain documentation, an evaluation of information systems, measure-specific findings, the process to review final reported rates for potential bias, and aggregate and categorical review findings. The report also will detail information system capabilities for performance measure data collection and will discuss additional data sources for possible performance measure reporting in the future.

The Contractor also will present results of any corrected programming logic, including corrections to numerators, denominators, or sampling for final measure calculation, as well as any required corrective actions. The Contractor will include in the report a summary of any major problems, corrective actions it identified and implemented, follow-up on corrective action results, and other recommendations to improve the quality of the PIHP's data.

In addition, the Contractor will present rate results indicating whether the validated measure is reportable or not reportable (due to a material bias in the calculated rate for a measure). The Contractor's final audit reports comply with all CMS validation of performance measures reporting requirements and provide the PIHP with valuable feedback and actionable recommendations to improve performance measure data collection and reporting activities. The Contractor will include in the reports the performance measure rate trends.

The Contractor can modify some of the above activities or include additional steps based on MDHHS' reporting specifications. The Contractor's approach to conducting audits allows for quick adjustments based on each state's requirements to modify the report process, as needed. The Contractor will conduct PMV for MDHHS calculated measures as well. The Contractor will follow the above process to conduct validation of performance measures that MDHHS calculates. The PMV processes will include the pre-on-site, on-site, and post-on-site components to confirm that the measures MDHHS calculates are accurate and reportable. Performance Validation Measure will include validation of rates that reflect performance outcomes of the final measure data used for quality assurance purposes.

D. **Validating Performance Improvement Projects Review**

The purpose of health care quality performance improvement projects (PIPs) is to assess and improve processes and outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted and reported in a methodologically sound manner. The CMS protocol specifies procedures for EQROs to use in evaluating the soundness and results of PIPs implemented by PIHPs.

Michigan has required performance improvement projects in response to CMS standards. Michigan PIHPs have engaged in numerous state-wide PIP topics including integration of physical and mental health care, improving timely access to ongoing mental health services, improving access for children, and increasing services provided by peer support specialists. Michigan also requires that the PIHPs select a topic for a second performance improvement project based on site review findings or performance indicators. Some of the topics selected for this second project have included coordination of care, implementation of family psychoeducation programs, integration of treatment for co-occurring disorders, and reducing inpatient psychiatric hospitalization recidivism.

The CMS protocol describes three activities that are to be undertaken in validating PIPs: A) assessing the PIHP's methodology for conducting the PIP, B) verifying actual PIP study findings, and C) evaluating overall validity and reliability of study results.

Activity One. Assessing the MCO's /PIHP's Methodology for Conducting the PIP, involves ten steps:

1. Review the selected study topic(s),
2. Review the study question(s),
3. Review the identified study population,
4. Review the selected study indicators,
5. Review sampling methods (if sampling was used),
6. Review the PIHP's data collection procedures
7. Review data analysis and interpretation of study results,
8. Assess the PIHP's improvement strategies,
9. Assess the likelihood that reported improvement is "real" improvement,
10. Assess the sustainability of documented improvement.

Activity Two, Verifying PIP Study Findings, is optional as it is resource intensive.

Activity Three describes how the Contractor will need to consider all validation findings and evaluate the degree to which the State should accept the findings of the PIHP's PIP as valid and reliable.

The detailed protocol is available on the Web at:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

Contractor's Plan:

Activity One: Assessing the PIHP's Methodology for Conducting the PIP

The Contractor's outcome-focused validation approach will assess the PIHP's methodology for conducting PIPs. This approach includes two key components of the quality improvement process:

- **Evaluation of the PIP's (clinical and/or nonclinical PIPs) technical structure**—The Contractor will evaluate the technical structure of each PIP to ensure the PIHP designed, conducted, and reported it in a methodologically sound manner, meeting all State and federal requirements. The Contractor's review will determine whether the PIHP's PIP(s) addressed the required steps in the CMS EQR Protocol 3: *Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (CMS Protocol 3). Executing this component successfully will ensure that reported PIP results are accurate and capable of measuring sustained improvement.
- **Evaluation of the PIP implementation**—The Contractor will review the PIHP's data analysis and interpretation of study results, improvement strategies, ability to achieve real improvement, and whether the PIHP sustained the improvement. Through this component, the Contractor will evaluate how well the PIHP improves its rates by implementing effective processes.

Activity Two: Verifying PIP Study Findings

To verify actual PIP findings, the Contractor will ensure that the study indicators are included in the list of performance measures to be validated annually as part of the performance measure validation activities. This will include an evaluation of the accuracy of PIP indicator outcomes the PIHP reports and a determination of the extent to which specific PIP indicators the PIHP calculates followed specifications established for the indicator. This process will ensure that the Contractor can assess the PIHP's ability to produce accurate results while eliminating the redundancy of re-auditing PIHP's data systems and processes. The Contractor will determine if any discrepancies exist within the reported PIP data and alert MDHHS. In the event one or more PIP indicators are not derived from validated performance measure indicators, the Contractor will ensure the use of an appropriate validation method, based on the data source and data collection methods the PIHP applies. Validation procedures may include primary source verification, replication and recalculation of numerator and denominator, and other methods as applicable to the indicator.

Activity Three: Evaluating Overall Validation Findings

The Contractor will use its outcome-focused approach to conduct validation of the PIHPs' PIPs. The Contractor's approach evaluates the PIHPs' compliance with each of the 10 steps listed in the current CMS Protocol 3. Using its PIP Validation Tool, the Contractor will assign each evaluation element within a given step a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIHPs' documentation and study indicator outcomes. In Step IX (real improvement achieved), statistically significant improvement over the baseline must occur across all study indicators to receive a *Met* score. For Step X (sustained improvement achieved), the Contractor will assess for sustained improvement once each study indicator achieves statistically significant improvement and a subsequent measurement period of data is reported.

Using its PIP Validation Tool and standardized scoring, the Contractor also will report the overall validity and reliability of the findings as one of the following:

- *Met* = high confidence/confidence in the reported study findings.
- *Partially Met* = low confidence in the reported study findings or statistical significant improvement was achieved for some but not all of the study indicators.
- *Not Met* = reported study findings that are not credible or that statistical significant improvement has not been achieved across all study indicators.

The Contractor has designated as critical elements some of the evaluation elements pivotal to the PIP process. For a PIP to produce valid and reliable results, all critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical element with a score of *Not Met* will receive an overall PIP validation rating of *Not Met*. A PIP that includes accurate documentation in alignment with the CMS protocol requirements has high validity and reliability. Validity is the extent to which the data collected for a PIP will measure its intent. Reliability is the extent to which an individual can reproduce the study results. For each completed PIP, the Contractor assesses threats to the validity and reliability of PIP findings and determines when a PIP no longer is credible.

The Contractor will provide the PIHPs with technical assistance throughout the process to ensure PIPs are methodologically sound and meet CMS requirements. The Contractor's technical assistance includes the following:

- Provides the PIHPs with timely feedback to make midcourse corrections and correct identified deficiencies.
- Provides information on industry standard practices for conducting PIPs.
- Sharing industry best practices, common issues, and performance trends with the PIHPs.
- Educating the PIHPs on quality improvement science techniques that include setting aims, establishing measures, determining interventions through process mapping and failure modes and effects analysis, and testing and evaluating interventions using Plan-Do-Study-Act (PDSA) cycles.

The Contractor's PIP validation goal will be to ensure that MDHHS and key stakeholders can have confidence that any reported improvement can be linked clearly to the PIHP's quality improvement strategies and processes. The Contractor's approach for assessing and documenting PIP findings provides a consistent, structured process and a mechanism to provide the PIHPs with specific feedback and recommendations for the PIP.

The Contractor will provide MDHHS and the PIHPs with plan-specific draft PIP validation reports that MDHHS reviews and approves before the Contractor finalizes the reports, including:

- Background information for each PIP submitted and validated.

- A discussion of the kinds of data gathered and the data collection sources.
- A discussion of all validation steps and the methods to conduct the validation.
- Specific validation findings for each evaluation element.
- Study indicator outcomes and the statistical significance of any change in performance.
- A critical evaluation of the PIHP's causal/barrier analysis processes, identified barriers, and implemented interventions.
- An evaluation of validity and reliability. For each validated PIP, the Contractor will assess and report any identified threats to the validity and reliability of findings and determine when a PIP is no longer credible.
- A discussion of conclusions drawn; identified strengths; opportunities for improvement; and recommendations to improve performance, processes, and outcomes of care.

The Contractor will develop plan-specific PIP validation reports in Microsoft Word to enable full modification flexibility, as required by MDHHS.

E. **Administration or Validation of consumer or provider surveys of quality of care**
The External Quality Review also includes optional activities that must be conducted at the discretion of the state. This voluntary protocol provides procedures for the administration or validation of managed care enrollees and other health care consumer surveys. The protocol is also applicable to surveys of other groups such as beneficiaries and providers.

The CMS protocol includes the following eight activities:

1. Identify survey purpose(s), objective(s) and intended use;
2. Select the survey instrument;
3. Develop the sampling plan;
4. Develop a strategy for maximizing the response rate;
5. Develop a quality assurance plan;
6. Implement the survey;
7. Prepare and analyze the data obtained from the survey; and
8. Document the survey process and results.

The detailed protocol for this optional activity is available on the Web at:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

CMS quality improvement principles require that Michigan have a comprehensive set of process, structure and outcomes measures that include feedback from the persons who receive services. In response to CMS, Michigan initiated use of the National Core Indicators (NCI) consumer interviews in 2011 and identified areas where Michigan results indicate the need for improvement, including the areas of health, choice and safety.

The NCI program began in 1997 and is now used in over 35 states to provide a standardized way to measure and track indicators for persons with intellectual/developmental disabilities (I/DD) who are served by the public mental health system. The NCI consumer survey is conducted on an annual cycle and addresses key areas of concern including employment, rights, service planning, community inclusion, choice and health and safety.

In 2017/2018 Michigan conducted 660 face-to-face NCI interviews with consumers who have a developmental disability who were receiving CMHSP services. BHDDA staff worked with CMHSPs, local ARC chapters, and Wayne State University to train interviewers, identify eligible consumers, obtain consumers' consent to participate, and coordinate, schedule and conduct interviews. Based on NCI protocols, the data collection included consumer responses to the interview questions, parent or guardian responses, as well as demographic information provided by the CMHSPs. DDI at Wayne State University was responsible for compiling this information and providing it to NCI in the required formats.

To assist the State in addressing the concerns expressed by CMS, the Contractor must work with Michigan to conduct the next cycle of NCI face-to-face consumer interviews for the FY2018/2019 fiscal year. The Contractor must be responsible for all tasks related to conducting this survey. MDHHS will identify a statewide random sample of 660 persons to meet NCI reliability standards. The Contractor must receive name and contact information from the local CMSHP for persons who have consented to participate in the survey. The Contractor must provide for interviewers who are trained by NCI (webinar) and who have experience with persons with the communication needs due to intellectual and/or developmental disability.

The trained interviewer must contact each individual/family member/guardian/home manager to schedule the interview. The Contractor's interviewers must follow the NCI guidelines to conduct a face-to-face interview using the NCI survey tool. Each interview takes about one hour. The Contractor must enter the results of each survey into the online NCI data collection. OR The Contractor must submit competed paper survey to DDI who must enter information onto the NCI online data collection system. During the previous fiscal year, these activities were completed within NCI's timeline with training occurring during November/December 2018 and the 660 randomly selected from a statewide sample interviews conducted between January and April 2019.

Details on NCIs survey protocols are available on the internet at:

http://www.nationalcoreindicators.org

Contractor's Plan:

The Contractor will perform surveys in accordance with 42 CFR §438.358(c)(2) and consistent with the CMS publication, *EQR Protocol 5: Validation and Implementation of Surveys: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (CMS Protocol 5) for survey administration and data collection and the requirements established by the state Medicaid agency.

The Contractor will implement each survey in accordance with the MDHHS-approved survey materials. To ensure it apprises MDHHS of its progress, the Contractor will develop an implementation plan that outlines the key dates and milestones for survey activities.

After survey completion, a Contractor analyst will upload the data files and a second analyst will evaluate the files and perform preliminary file validation. The Contractor will then use the analytic plan, approved by MDHHS, to perform the most appropriate and cost-effective analysis of the survey data. In reporting the results to MDHHS, the Contractor will document all survey process activities and include analysis results in tabular and graphical format.

Upon request, the Contractor will work with MDHHS to administer surveys that will be beneficial in obtaining information to improve services to the Medicaid beneficiaries. The Contractor has selected DataStat as its subcontractor for data collection if this activity is requested by MDHHS. The Contractor will obtain MDHHS' approval to use DataStat as a subcontractor prior to starting the activity.

The Contractor will administer, validate, and implement surveys in accordance with CMS Protocol 5 and is thoroughly familiar with all eight specified activities that ensure a methodologically sound survey: 1) identifying the survey purpose and objectives; 2) selecting the appropriate survey instrument; 3) developing a sampling plan; 4) developing a strategy to maximize response rates; 5) implementing the survey; 6) performing quality checks during survey administration; 7) preparing and analyzing the data obtained from the survey; and 8) documenting the survey process and results.

Conduct National Core Indicators (NCI) Consumer Interviews

The Contractor will be responsible for all tasks related to conducting the NCI consumer survey. As an NCQA-HEDIS survey vendor, the Contractor will manage and oversee all activities related to the NCI survey. The Contractor's subcontractor, Developmental Disabilities Institute (MI-DDI) at Wayne State University, will administer the NCI consumer survey.

Conducting NCI Face-to-Face Consumer Interviews

The Contractor's survey team will conduct the NCI face-to-face consumer interviews. The team will collaborate with the MDHHS NCI coordinator and the MDHHS data office to obtain a random sample of 660 individuals to meet the NCI reliability standards. Based on NCI program implementation experience, the Contractor will request MDHHS to provide a random sample of 4,000 individuals to ensure the completion of 660 interviews. Once the sample is drawn, the Contractor will send to local community mental health (CMH) liaisons (jointly identified by the CMHs and the MDHHS NCI coordinator) their respective samples to obtain background data. The team will communicate weekly with each local CMH liaison to address any problems and/or receive the permissions, background data, names, and contact information of persons who have consented to participate in the survey, and to ensure that timelines are met, and material is provided to facilitate the interviews. Once permission and background data are received, the team members will work with the survey participants, including the beneficiaries, family members, guardians, and/or home managers to schedule their one-hour face-to-face interviews. The interviewers will follow the NCI guidelines to conduct a face-to-face interview using the NCI survey tool.

In alignment with NCI protocols the Contractor will provide NCI training for all interviewers. The Contractor will recruit interviewers who have experience with persons with specific communications needs due to intellectual and/or developmental disability. NCI will train all interviewers via webinar or in person. Interviewer training will include an outline of the expectations related to maintaining confidentiality with protected health information, which includes all means by which information can be used to identify a consumer's identity. Throughout the survey administration process, the Contractor will ensure ongoing oversight of interviewers' adherence to maintaining consumer data confidentiality.

Although the Contractor will set a goal to have all interviews completed by April 30, 2020, there may be instances when the beneficiaries are not available for a face-to-face interview until after this goal date. To accommodate each beneficiary's interview date preference, the Contractor will continue to conduct the interviews throughout May and June, as necessary, but will ensure completion of each interview and entry of the resulting data into the system before the NCI June 30, 2020, deadline.

Throughout the survey process, the Contractor will provide MDHHS with weekly progress reports, documenting activities, outputs, issues, and timeline adherence.

Preparing and Submitting Survey Results to NCI Data Collection System

Upon completing the face-to-face interviews, the Contractor will enter all responses into the NCI Online Data Entry Survey Application system by June 30, 2020. Because Michigan NCI is part of a national program, the national NCI will analyze the data and prepare a State report and comparative reports with other states, and will provide the MDHHS NCI coordinator with these reports. At MDHHS' request, the Contractor will conduct additional analyses and/or present NCI consumer survey information to stakeholders.

For the NCI Consumer Survey, the Contractor intends to use subcontractor Developmental Disabilities Institute (MI-DDI) at Wayne State University, included in the Schedule B.2 Pricing. In the event MDHHS requests consumer and/or provider surveys in addition to the NCI Consumer Survey, the Contractor will submit proposed subcontractor information to MDHHS for review and approval prior to initiating the surveys.

F. **Additional Requirements Specific to this RFP**

Independence: The Contractor and its subcontractors must be independent from the State Medicaid agency and from the Managed Care Organizations or PIHPs that they review. To qualify as "independent":

1. A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and
2. A State agency, department, university, or other State entity must be governed by a Board or similar body, the majority of whose members are not government employees.
3. An EQRO may not:
    a. Review a particular MCO or PIHP if either the EQRO or the MCO or PIHP exerts control over the other. (As used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:
        i. Stock Ownership;
        ii. Stock options and convertible debentures;
        iii. Voting trusts;
        iv. Common management, including interlocking management, and

v. Contractual relationships

b. Deliver any health care services to Medicaid recipients;
c. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or PIHP services, except for the related activities specified in 42 CFR 438.358; or
d. Have a present, or know of a future, direct or indirect financial relationship with an MCO or PIHP that it must review as an EQRO.

1.2. Transition

The Contractor must work with the State and/or the previous contractor within 90 days for an orderly transition. Contractor must provide a detailed transitional plan timeline to the State within 15 days post-contract. The Contractor must allow as many personnel as practicable to attend meetings and receive hardcopy and/or electronic files to help maintain the continuity and consistency of the services required by the Contract. The Contractor must comply with reasonable detailed specifications for all Services/Deliverables previously provided to the State to properly provide the Service/Deliverables required under this Contract.

The Contractor must acquire any software required to meet Services and Deliverable criteria under this Contract. This must include any documentation being used by the Contract to perform the Services under this Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level.

1.3. Training

The Contractor must provide the following training at the request of MDHHS: Technical assistance for new and revised federal regulations or policy and data systems, areas of quality improvement opportunity to the PIHPs, and/or at the request of the agency, conduct a presentation at the Michigan Association of Community Health Board conference.

Contractor's Additional Training:

Administering Required Training

Trainings will include new and revised federal regulations, policy topics, data systems, and areas of quality improvement opportunity (to the PIHPs). Additionally, the Contractor will provide project-specific training and technical assistance to MDHHS and the PIHPs, as necessary, to ensure successful completion of each EQR activity included as part of the Michigan EQRO contract. At the request of MDHHS, the Contractor will also conduct a presentation at the Michigan Association of Community Health Board conference.

Training Capabilities and Proposed Trainings

The Contractor will offer insight, recommendations, and proposals during each stage of the contract and for all aspects of the EQR activities. An important activity within the Contractor's EQRO contracts is the provision of consultation, training, and technical assistance to state Medicaid agencies and PIHPs at both the staff and committee levels.

The Contractor's approach to providing technical assistance and training to MDHHS and its contracted PIHPs will be flexible and responsive to the specific needs, culture, and MDHHS contract requirements, and EQR activity requirements. The Contractor will provide technical assistance and training that:

- Addresses areas that have the highest priority with the probability of producing improvement associated with (1) an aspect of care related to quality, access, timeliness, and/or beneficiary health outcomes; (2) improved performance related to meeting specific MDHHS contract requirements; and (3) strategies for engaging providers and beneficiaries in embracing early detection of disease and illness, early intervention, prevention, and health promotion activities to achieve overall population health.
- Facilitates improvement activities in an area where performance has not met MDHHS' expectations.
- Facilitates accurate and timely reporting of technical data to CMS or other stakeholders.

Assessing the Need for Technical Assistance and Training

The Contractor will identify and provide the necessary technical assistance and training to the PIHPs—individually or as a group, as needed—to ensure that each PIHP is fully prepared for the role it will play within an activity. The Contractor will review for the PIHP the timelines and due dates for its active participation; the staff, information, and other resources it will need for the activity; and how it will communicate the outcome and results of the activity (usually a report). If the Contractor discovers that PIHP staff members are struggling with EQR

concepts or with meeting data submission requirements, it will notify MDHHS and recommend a specific technical assistance or training strategy specific for the PIHP to guide them through the EQR activity.

Proposed Approach for Providing Technical Assistance and Training

The Contractor's approach to conducting technical assistance and training includes specific and proven steps, as follows:

- Once the need for technical assistance or training on a topic is identified, the Contractor will develop and submit to MDHHS for review a detailed written plan for providing assistance on that topic. The plan will include the following:
  - A detailed approach for providing technical assistance or training, including the topic and the target audience.
  - A determination of how the technical assistance or training will be provided to MDHHS and/or the PIHPs (i.e., on-site, conference call, webinar, and/or in writing).
  - In addition to the Contractor's project director, the Contractor's activity leaders and staff members who will conduct the technical assistance or provide the training.
  - The anticipated date for completing the technical assistance or training session.
  - The anticipated goals and expected outcome of the technical assistance or training session.
- Upon receiving MDHHS' written approval, the Contractor will implement the plan and initiate the planning and design for the technical assistance or training.
- The Contractor will provide the agenda and handouts for the presentations and will facilitate the discussion.

The Contractor will observe and assess each PIHP's participation as the training is conducted, will report to MDHHS regarding any concerns, and will provide recommendations for additional technical assistance or training interventions to ensure activities are conducted as successfully as possible.

For any PIHPs that are new to the Medicaid managed care program or have not been involved in a particular EQR activity, the Contractor will provide technical assistance by offering introductory webinars to help them become familiar with the EQR activities in which they will participate. The Contractor will offer technical assistance and training throughout the cycle of each EQR activity via teleconferences and webinars so projects stay on task and PIHPs are fully aware of their roles and responsibilities throughout the EQR activity. The Contractor will submit all technical assistance and training presentation materials to MDHHS for review and approval prior to conducting technical assistance and training with the PIHPs.

Training Documentation and Materials

The Contractor will provide all technical assistance and training materials, including an agenda, a copy of the presentation, and any applicable resources or handouts to the PIHPs, either prior to or during the technical assistance or training session based on MDHHS' preference.

Proposed Examples of Technical Assistance and Training That Could be Offered

The Contractor will provide technical assistance to MDHHS and the PIHPs in the form of written communication, conference calls, in-person meetings, and written reports as needed to achieve the most positive outcomes. In addition to assisting the PIHPs on their participation in the mandatory and optional EQR activities, the Contractor's staff members will provide technical assistance and training for the following activities:

- Selecting and/or assisting in the development of performance measure indicators used for quality improvement (for both MDHHS and PIHPs).
- Developing and tracking PIPs and other quality initiatives (for both MDHHS and PIHPs).
- Developing EQR result summaries to share with MDHHS leadership (for MDHHS).
- Implementing the new mandatory EQR activity – validation of network adequacy (for both MDHHS and PIHPs).
- Identifying national healthcare trends and best practices that can be shared with the PIHPs (for both MDHHS and PIHPs).
- Providing clinical consultation for program evaluation (for MDHHS).
- Providing instruction to the PIHPs for continuous evaluation and improvement of health initiatives.

2. Acceptance

2.1. Acceptance, Inspection and Testing

The State will use the following criteria to determine acceptance of the Contract Activities:

The Contractor must provide PIHP-specific reports for each of the three components of the external quality review as well as an Executive Summary. The Contractor must submit a draft version of the Executive Summary to MDHHS by December 31, 2020 for review and approval. Each of these reports must be reviewed by MDHHS Program Manager as well as by any MDHHS staff determined by the MDHHS Program Manager. The MDHHS Program Manager will have the final determination for approval of these reports. Printing and distribution of the report must not occur until after MDHHS has given final approval to revisions of the draft document.

2.2. Final Acceptance

Final Acceptance will be given at the completion of the activities detailed in the above work plan and the final approval of the reports on three components of the External Quality Review as well as the Executive Summary.

3. Staffing

3.1. Contractor Representative

The Contractor must appoint a single point of contact, specifically assigned to State of Michigan accounts, that will respond to State inquiries regarding the Contract Activities, answering questions related to ordering and delivery, etc. (the "Contractor Representative").

Within five working days of the award of the Contract, the Contractor must submit to the MDHHS Program Manager for final approval the Contractor's project organizational structure. This must include the Contractor's staffing table with names and title of personnel assigned to the project. This must be in agreement with staffing of accepted proposal. The State of Michigan retains the right to final approval of this plan.

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

Contractor Representative:

Lee Ann Dougherty

3.2. Customer Service Toll-Free Number

The Contractor must specify its toll-free number for the State to make contact with the Contractor Representative. The Contractor Representative must be available for calls during the hours of 8 am to 5 pm ET.

Contractor's Toll-Free Number:

1-844-472-4426

3.3. Work Hours

The Contractor must provide Contract Activities during the State's normal working hours Monday – Friday, 7:00 a.m. to 6:00 p.m. EST, and possible night and weekend hours depending on the requirements of the project.

3.4. Key Personnel

All staff assigned to this Contract must have at a minimum the following:

A. Demonstrated experience and knowledge of:
    1. Managed care delivery systems, organizations, and financing
    2. Quality assessment and improvement methods; and
    3. Research design and methodology, including statistical analysis

Prior to any proposed staffing changes, the Contractor must submit to the MDHHS Program Manager for final approval the Contractor's project organizational structure or other charges payable under this contract.

Key Personnel Table

Position	Name	Physical Location
Project Director, State & Corporate Services (S&CS)	Lee Ann Dougherty, MHA	Ohio

Project Manager, S&CS	Ruth Ruby, RN, BSN	Iowa
Associate Executive Director, Performance Improvement Projects (PIPs), S&CS	Christi Melendez, RN, CPHQ	Arizona
Director, Audits, S&CS	Mariyah Badani, MBA, CHCA	Arizona
Director, Data Science and Advanced Analytics (DSAA)	Amber Saldivar, MHSM	Arizona

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

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

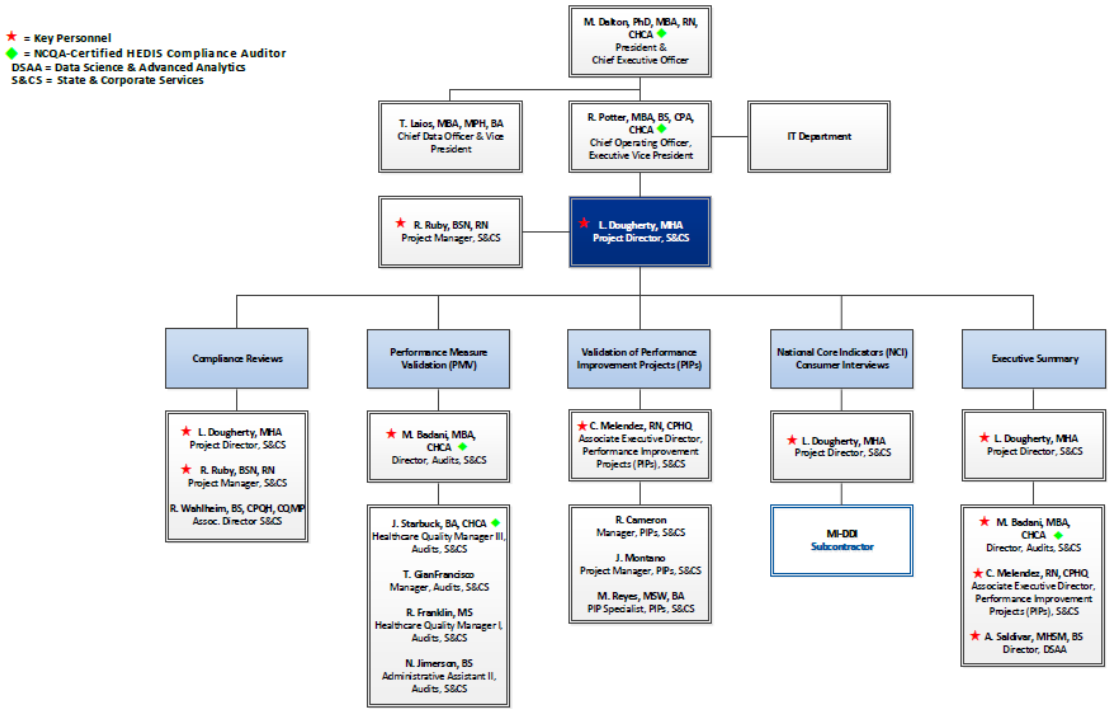
Contractor acknowledges and agrees that each of the Unauthorized Removal Credits assessed above: (i) is a reasonable estimate of and compensation for the anticipated or actual harm to the State that may arise from the Unauthorized Removal, which would be impossible or very difficult to accurately estimate; 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.

The Contractor must identify the Key Personnel, indicate where they will be physically located, describe the functions they will perform, and provide current chronological résumés.

3.5. Organizational Chart

The Contractor must provide an overall organizational chart that details staff members, by name and title, and subcontractors.

A.2 – HSAG Michigan EQRO Services for PIHPs
Project Team Organization Chart



3.6. Disclosure of Subcontractors

If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

The legal business name; address; telephone number; a description of subcontractor's organization and the services it will provide; and information concerning subcontractor's ability to provide the Contract Activities.

The relationship of the subcontractor to the Contractor.
Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.

A complete description of the Contract Activities that will be performed or provided by the subcontractor.

Subcontractor	
Legal business name and full address.	Michigan Developmental Disabilities Institute (MI-DDI) Wayne State University 5057 Woodward Avenue, 13th Floor Detroit, MI 48202
State in which business was incorporated.	Michigan
Phone number.	313.577.2654
Description of subcontractor's organization and the services it will provide.	With the Contractor's oversight, MI-DDI will manage the NCI consumer survey activity, developing a detailed protocol for survey administration, training surveyors, interviewing participants, and entering survey data into the NCI online data collection system (ODESA). MI-DDI also will be responsible for presenting information related to the NCI consumer survey to MDHHS and other entities, as requested by MDHHS.

Description of the Contract Activities that will be performed or provided by the subcontractor.	MI-DDI will work with local community mental health services programs to obtain interviewee background information, provide trained and experienced interviewers to conduct the interviews, schedule and conduct face-to-face interviews, enter the results of at least 660 completed interviews into NCI's ODESA, submit weekly summative reports on subcontract work to the Contractor, and attend meetings with MDHHS and the Contractor, as requested.
Information concerning subcontractor's ability to provide the identified Contract Activities for their business.	MI-DDI has a successful track record conducting program evaluations and beneficiary satisfaction studies, addressing such issues as special education advocacy, community program access and outcomes, self-determination, and satisfaction with public services across the lifespan. Specific to the Michigan NCI program implementation, MI-DDI staff members have worked with MDHHS on its NCI program since its inception, supporting sampling, training, interviewing, and data analyses activities. MI-DDI has been responsible for conducting the in-person interviews (working directly with local mental health agencies to confirm sampling requirements, consents, and liaison activities with interviewees) and has been solely responsible for data collection and entry of the survey information into the ODESA data collection tool.
The relationship of the subcontractor to the Contractor.	The Contractor has a current contract with MI-DDI to conduct the survey administration phase of the 2019 NCI consumer interviews for MDHHS.
If the Contractor has a previous working experience with the subcontractor, provide the details of that previous relationship.	The Contractor has contracted with MI-DDI since January 2015 to conduct the Michigan NCI consumer surveys. MI-DDI has been responsible for working with community Mental health services programs liaisons to obtain presurvey and background information for beneficiaries selected as part of the survey sample; scheduling and conducting in-person interviews of beneficiaries selected for the sample; ensuring that all interviewers are appropriately trained to administer the survey; ensuring oversight of interviewers' adherence to maintaining confidentiality of all beneficiary data; and entry of all data collected from the surveys into the NCI web-based data collection tool.

3.7. SPECIFIC STANDARDS

IT Policies, Standards and Procedures (PSP)

Contractors are advised that the State has methods, policies, standards and procedures that have been developed over the years. Contractors are expected to provide proposals that conform to State IT policies and standards. All services and products provided as a result of this RFP must comply with all applicable State IT policies and standards. Contractor is required to review all applicable links provided below and state compliance in their response.

Public IT Policies, Standards and Procedures (PSP): http://www.michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html

Note: Not all applicable PSP's are available publicly. Controlled PSP's applicable to the RFP are available after signing and returning to the State the required Nondisclosure Agreement (NDA) agreement. Failure to return a signed NDA may be grounds for disqualification.

Secure Web Application Standard

Contractor's solution must meet the State's Secure Application Development Standards as mandated by the State.

Secure Application Development Life Cycle (SADLC)
Contractor is required to meet the States Secure Application Development Life Cycle requirements that include:

Security Accreditation
Contractor is required to complete the State Security Accreditation process for the solution.

Application Scanning

On-Premise solutions
The State may scan the application using its application scanning tools. Contractor will need to provide the resources, at its sole expense, to complete any analysis remediation and validation required by the results of the scan.

Externally hosted solutions
Contractor is required to grant the right to the State to scan either the application code or a deployed version of the solution; or in lieu of the State performing a scan, Contractor will provide the State a vulnerabilities assessment after Contractor has used a State approved application scanning tool. These scans must be completed and provided to the State on a regular basis or at least for each major release.

For COTS or vendor owned applications, Contractor, at its sole expense, must provide resources to complete the scanning and to complete the analysis, remediation and validation of vulnerabilities identified by the scan as required by the State Secure Web Application Standards.

Types of scanning and remediation may include the following types of scans and activities

- Dynamic Scanning for vulnerabilities, analysis, remediation and validation
- Static Scanning for vulnerabilities, analysis, remediation and validation
- Third Party and/or Open Source Scanning for vulnerabilities, analysis, remediation and validation

Infrastructure Scanning

On-Premise solutions
The State may scan the application using its infrastructure scanning tools and remediate infrastructure vulnerabilities internally.

Externally hosted solutions
A Contractor providing Hosted Services must scan the infrastructure at least once every 30 days and provide the scan's assessment to the State in a format that can be uploaded by the State and used to track the remediation.

Acceptable Use Policy
To the extent that Contractor has access to the State's computer system, Contractor must comply with the State's Acceptable Use Policy, see http://michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html. All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State's system. The State reserves the right to terminate Contractor's access to the State's system if a violation occurs.

Look and Feel Standard
All software items provided by the Contractor must adhere to the following Look and Feel Standards: http://www.michigan.gov/documents/som/Look_and_Feel_Standards.

ADA Compliance
The State is required to comply with the Americans with Disabilities Act of 1990 (ADA), and has adopted a formal policy regarding accessibility requirements for websites and software applications. The State is requiring that

Bidder's proposed Solution, where relevant, to level AA of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0. Bidder may consider, where relevant, the W3C's Guidance on Applying WCAG 2.0 to Non-Web Information and Communications Technologies (WCAG2ICT) for non-web software and content. The State may require that Bidder complete a Voluntary Product Accessibility Template for WCAG 2.0 (WCAG 2.0 VPAT) or other comparable document for the proposed Solution.
http://www.michigan.gov/documents/dmb/1650.00_209567_7.pdf?20151026134621

SUITE Documentation
In managing its obligation to meet the above milestones and deliverables, the Bidder is required to utilize the applicable State Unified Information Technology Environment (SUITE) methodologies, or an equivalent methodology proposed by the Bidder. The Bidder is required to review http://www.michigan.gov/suite and demonstrate how each PMM/SEM requirement will be met. Bidders wishing to use their own documents must submit an example of the document that will be substituted. If the Bidder deems a document to be non-applicable, please provide reasons for the determination. The State reserves the right to give final approval of substituted documents and items marked as non-applicable.

SUITE's primary goal is the delivery of on-time, on-budget, quality systems that meet customer expectations. SUITE is based on industry best practices, including those identified in the Project Management Institute's PMBoK and the Capability Maturity Model Integration for Development. It was designed and implemented to standardize methodologies, processes, procedures, training, and tools for project management and systems development lifecycle management. It offers guidance for efficient, effective improvement across multiple process disciplines in the organization, improvements to best practices incorporated from earlier models, and a common, integrated vision of improvement for all project and system related elements.

While applying the SUITE framework through its methodologies is required, SUITE was not designed to add layers of complexity to project execution. There should be no additional costs from the Bidder, since it is expected that they are already following industry best practices which are at least similar to those that form SUITE's foundation.

SUITE's companion templates are used to document project progress or deliverables. In some cases, Bidders may have in place their own set of templates for similar use. Because SUITE can be tailored to fit specific projects, project teams and State project managers may decide to use the Contractor's provided templates, as long as they demonstrate fulfillment of the SUITE methodologies.

Agency Specific Standards
Because the system contains Federal Tax Information, Contractor shall comply with all application security requirements outlined in IRS Publication 1075 including, but not limited to, the Exhibit 7 Safeguarding Contract Language embedded below:


CONTRACT LANGUAGE FOR TECH


Exhibit 7 General Services Requirement

See the following links for further information:
- https://www.irs.gov/privacy-disclosure/additional-requirements-for-publication-1075
- https://www.irs.gov/pub/irs-pdf/p1075.pdf

4. Project Management
4.1. Project Plan
Identify the project plan and how it will be managed or ask Contractor to propose a project plan. Project plan should identify items such as the required contact personnel; the date the project plan must be submitted to the State; project management process; project breakdown identifying sub-projects, tasks, and resources required; expected frequency and mechanisms for updates/progress reviews; process for addressing issues/changes; and individuals responsible for receiving/reacting to the requested information.

The Contractor will carry out this project under the direction and control of the Program Manager of the Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, Program Development, Consultation and Contracts Division. Although there will be continuous liaison with the Contractor team, the MDHHS Program Manager must meet quarterly at a minimum, with the Contractor's project manager for the purpose of reviewing progress and providing necessary guidance to the Contractor in solving problems which arise.

Within 30 calendar days of the Effective Date, the Contractor must submit a project plan to the Program Manager for final approval. 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 State may request other meetings, as it deems appropriate.

4.3. Reporting
The Contractor must submit, to the Program Manager brief written or oral monthly summaries of progress that outline the work accomplished during the reporting period; work to be accomplished during the subsequent reporting period; problems, real or anticipated, which should be brought to the attention of the MDHHS' Program Manager; and notification of any significant deviation from previously agreed upon work plans.

5. Pricing
5.1. Price Term
Pricing is firm for the entire length of the Contract.

5.2. Price Changes
Adjustments will be based on changes in actual Contractor costs. Any request must be supported by written evidence documenting the change in costs. The State may consider sources, such as the Consumer Price Index; Producer Price Index; other pricing indices as needed; economic and industry data; manufacturer or supplier letters noting the increase in pricing; and any other data the State deems relevant.

Following the presentation of supporting documentation, both parties will have 30 days to review the information and prepare a written response. If the review reveals no need for modifications, pricing will remain unchanged unless mutually agreed to by the parties. If the review reveals that changes are needed, both parties will negotiate such changes, for no longer than 30 days, unless extended by mutual agreement.

The Contractor remains responsible for Contract Activities at the current price for all orders received before the mutual execution of a Change Notice indicating the start date of the new Pricing Period.

6. Ordering
6.1. Authorizing Document
The appropriate authorizing documents for the Contract will be a signed Master Agreement as well as an Agency Issued Delivery Order (DO).

7. Invoice and Payment
7.1. Invoice Requirements
All invoices must reflect actual work done. Specific details of invoices and payments must be agreed upon between the Program Manager and the Contractor.

20 percent of the total price must remain for final payment.

All invoices submitted to the State must include: (a) date; (b) purchase order; (c) quantity; (d) description of the Contract Activities; (e) unit price; (f) shipping cost (if any); and (g) total price. Overtime, holiday pay, and travel expenses will not be paid.

7.2. Payment Methods
The State will make payment for Contract Activities via Electronic Funds Transfer (EFT).

8. Liquidated Damages

Late or improper completion of the Contract Activities will cause loss and damage to the State and it would be impracticable and extremely difficult to fix the actual damage sustained by the State. Therefore, if there is late or improper completion of the Contract Activities the State is entitled to collect liquidated damages in the amount of $5,000 and an additional $100 per day for each day Contractor fails to remedy the late or improper completion of the Work.

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization (EQRO) and Customer Satisfaction Survey
for the Michigan Department of Health & Human Services (MDHHS)

SCHEDULE B.1
PRICING

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

2. **Quick payment terms**: 0.5 % discount off invoice if paid within 30 days after receipt of invoice.

3. The following is a breakdown of the Customer Assessment of Healthcare Providers and Systems (CAHPS) surveys and reports activities:

- **Adult Medicaid CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item sent to the adult Fee-for-Service (FFS) population only and reporting of Adult FFS and Medicaid health plans (MHPs) CAHPS Survey results. The 11 Health plans will submit their audited CAHPS 5.0 Survey data and this data will be analyzed by the contractor.

- **Child Medicaid CAHPS Survey** activities must include administration of the CAHPS 5.0 Child Medicaid Survey without the Children with Chronic Conditions (CCC) measurement set ("CAHPS 5.0 Child Medicaid Survey") to child Medicaid members enrolled in the FFS population and MHPs, as well as reporting of Child Medicaid FFS and MHP CAHPS Survey results.

- **CSHCS Survey** activities must include administration of the CSHCS Survey to CSHCS child members enrolled in the FFS population (Medicaid and non-Medicaid) and MHPs, including reporting of the survey results.

- **Adult ICO CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to adult members dually eligible for Medicare and Medicaid (i.e., dual eligible adult members) enrolled in the 7 ICO health plans participating in Michigan's Medicare-Medicaid Dual Eligible Demonstration project, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Adult ICO CAHPS HCBS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to members dually eligible for Medicare and Medicaid (i.e., dual eligible adult members) enrolled in the 7 ICO health plans participating in Michigan's Medicare-Medicaid Dual Eligible Demonstration project, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings. This report will include results from the survey done for the population which receives inhouse and community-based services. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

- **Adult HMP CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Medicaid Survey with the HEDIS® supplemental item set to adult members enrolled in the 11 HMP health plans participating in Michigan's Medicaid expansion program, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Adult HMP Dental CAHPS Survey** activities must include administration of the CAHPS 5.0 Adult Dental Survey with the HEDIS® supplemental item set to adult members enrolled in the 11 HMP health plans who administer dental benefits or subcontract with a dental contractor participating in Michigan's Medicaid expansion program, as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings.

- **Healthy Kids Dental CAHPS Survey** activities must include administration of the CAHPS 5.0 Dental Survey with the HEDIS® supplemental item sent to Healthy Kids Dental members enrolled in the 2 Dental health plans as well as reporting of CAHPS survey results in a single aggregate report with plan-specific findings

Table 1:
*The actual population sizes can vary throughout the term of the contract.

CAHPS Survey Tasks	Population Size Estimate*	Year One Pricing	Year Two Pricing	Year Three Pricing	Year four Pricing	Year five Pricing	Total five-Year Pricing for CAHPS Services
FFS – Adult Medicaid CAHPS Survey	288,179	$19,961.63	$20,760.91	$21,592.20	$22,456.47	$23,354.69	$108,125.90
FFS – Child Medicaid CAHPS Survey	158,814	$21,863.80	$22,738.74	$23,647.63	$24,594.35	$25,577.93	$118,422.45
MHP – Adult Medicaid Statewide Report	466,041	$5,228.30	$5,437.82	$5,655.10	$5,881.11	$6,115.85	$28,318.18
MHP – Child Medicaid CAHPS Surveys	775,176	$187,268.20	$194,758.54	$202,549.58	$210,651.02	$219,077.41	$1,014,304.75
FFS – CSHCS Survey	8,982	$35,172.20	$36,578.70	$38,042.43	$39,564.36	$41,146.43	$190,504.12
MHP – CSHCS Surveys	23,619	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
ICO – Adult CAHPS Surveys	37,743	$101,714.20	$105,782.38	$110,013.52	$114,414.41	$118,990.87	$550,915.38
ICO- Adult CAHPS HCBS surveys (receiving inhouse and community-based services)	12,000	$187,268.20	$194,758.54	$202,549.58	$210,651.02	$219,077.41	$1,014,304.75
HMP – Adults CAHPS Surveys	697,709	$139,738.20	$145,327.34	$151,140.55	$157,186.56	$163,474.10	$756,866.75
HMP- Adults Dental Plan CAHPS surveys	697,709	$144,491.20	$150,270.46	$156,281.55	$162,532.23	$169,034.14	$782,609.58
HKD – Child Dental Plan CAHPS surveys	969,196	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,386.59	$293,477.38
Total Five-Year Price							**$5,614,715.99**

The following is a breakdown of the EQRO Services for Michigan's Medicaid Managed Care Organizations:

PIP

1. The Contractor must provide MDHHS with an objective comprehensive of whether the MHP's, DHP's and ICO's PIP is methodologically sound.
2. The Contractor must develop a template and evaluate PIP for each MHP, DHP, ICO to assess the soundness and results of the PIP.
3. The Contractor must provide technical assistance to MDHHS and to ensure that the PIP projects are consistent with EQR protocol.

Technical Report

1. The Contractor must produce a detailed, a technical report that describes the data from all EQR related activities, which are aggregated and analyzed that summarize the quality, timeliness, and access to care furnished to MHP including HMP, a separate report for DHP and a separate report for ICO.
2. The Contractor must review annual MHP compliance review, validate performance measures results, validate network adequacy, evaluate MHP quality improvement projects, evaluate CAHPS survey results, and evaluate clinical and/or nonclinical focused studies conducted by EQRO during preceding year (at the State's discretion).

HEDIS and Other Performance Measures

1. The Contractor must utilize the most current National Committee for Quality Assurance (NCQA) Medicaid benchmarks to accurately evaluate and perform HEDIS analysis.
2. The Contractor must perform comprehensive review and analysis of contracted Michigan MHPs and IDSS results for each reporting year of this contract.
3. The Contractor must comparatively review MHP quality of care outcomes and performance measures and utilize the findings as part of this task for inclusion in EQR technical report.

Consumer Guide

1. The Contractor must utilize the results of HEDIS Analysis and CAHPS findings to perform statistical tests to compare MHP/DHP performance to Statewide means, benchmarks, and goals where appropriate, and conduct descriptive comparative analysis using NCQA benchmarks.
2. The Contractor must propose two methodologies to calculate MHP/DHP specific results for use in the Consumer Guide and/or Performance Bonus using Medicaid 50th percentile benchmark or Michigan Weighted Average (Aggregate Rate) as the reference point.
3. The Contractor must maintain the five categories addressed in the current Consumer Guide.

Table 2:

EQRO Tasks – MHP including HMP Dental	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$73,268.95	$76,200.29	$79,248.03	$82,417.99	$85,715.02	$396,850.28
Technical Report	$82,702.20	$86,009.90	$89,450.49	$93,028.82	$96,749.74	$447,941.15
HEDIS and Other Performance Measures	$120,726.20	$125,554.86	$130,577.52	$135,800.97	$141,232.97	$653,892.52
Consumer Guide	$33,271.00	$34,601.84	$35,986.03	$37,425.51	$38,922.22	$180,206.60
Network Adequacy with Secret shopper call	$204,379	$222,773	$231,685	$240,952	$250,590	$1,150,378.29
Total Five-Year Price						**$2,829,268.84**

EQRO Tasks - HKD	Year One Pricing	Year Two Pricing	Year Three Pricing	Year Four Pricing	Year Five Pricing	Total Five Year Pricing for EQRO Activities
PIP Work Plan	$13,321.98	$13,855.48	$14,409.35	$14,985.53	$15,584.99	$72,157.33
Technical Report	$25,666.20	$26,692.46	$27,760.43	$28,871.08	$30,025.38	$139,015.55
HEDIS and Other Performance Measures	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
Consumer Guide	$25,666.20	$26,692.46	$27,760.43	$28,871.08	$30,025.38	$139,015.55
Network Adequacy and Secret Shopper Call	$101,714.20	$111,885.62	$116,361.20	$121,015.26	$125,858.47	$576,834.75
			Total Five-Year Price			**$1,220,501.53**
EQRO Tasks - ICO	**Year One Pricing**	**Year Two Pricing**	**Year Three Pricing**	**Year Four Pricing**	**Year Five Pricing**	**Total Five Year Pricing for EQRO Activities**
PIP Work Plan	$46,625.96	$48,491.27	$50,430.30	$52,447.90	$54,545.04	$252,540.47
Technical Report	$54,184.20	$56,351.18	$58,605.46	$60,949.95	$63,387.56	$293,478.35
HEDIS and Other Performance Measures Validation	$63,690.20	$66,237.42	$68,887.46	$71,643.23	$74,508.61	$344,966.92
Compliance Review	$110,233.71	$110,233.71	$110,233.71	$123,997.04	$123,997.04	$578,695.21
Network Adequacy and Secret Shopper Calls	$187,268.20	$205,995.02	$214,235.17	$222,804.15	$231,718.45	$1,062,020.99
			Total Five-Year Price			**$2,531,701.94**

Total Five-Year Price from Table 1	$5,614,715.99
Total Five-Year Price from Table 2 (MHP, HKD, ICO)	$6,581,472.31
Total Five- Year Contract Price	**$12,196,188.30**

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization Services for Prepaid Inpatient Health Plans – Michigan Department of Health and Human Services

SCHEDULE B.2
PRICING

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

2. **Quick payment terms**: 0.5 % discount off invoice if paid within 30 days after receipt of invoice.

3. The price list below is the Contractor's firm pricing for the duration of this Contract:

Annual Task Title	# Units*	Total Price
Validation of Performance Improvement Projects	10 PIHPs	**$72,155.39**
Review of Compliance with Medicaid Managed Care Proposed Regulations	10 PIHPs	**$227,229.29**
Validation of Performance Indicators	10 PIHPs	**$130,736.60**
Validation and Implementation of Surveys	10 PIHPs	**$256,633.87**
Total Annual Contract Price		**$686,755.15**
Total 5 Year Contract Price		**$3,433,775.75**

* MDHHS currently contracts with 10 PIHPs, however with the Section 298 Project may require an additional PIHP.

STATE OF MICHIGAN

Contract No. 190000001404
External Quality Review Organization (EQRO) and Customer Satisfaction Survey
for the Michigan Department of Health & Human Services (MDHHS)

SCHEDULE C

HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the Michigan Department of Technology, Management and Budget ("DTMB", "Business Associate 1") on behalf of **Michigan Department of Health and Human Services** ("Covered Entity") and **Health Services Advisory Group, Inc** "Business Associate 2".

RECITALS

A. Under this Agreement, Business Associate 2 will collect or receive certain information on the Covered Entity's behalf, 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 Agreement.

B. Covered Entity and each Business Associate intend to protect the privacy and provide for the security of PHI collected or received by the Business Associate under the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HIPAA Rules, as amended.

C. The HIPAA Rules require the Covered Entity to enter into an agreement containing specific requirements with Business Associate 1, and likewise Business Associate 1 must enter an agreement with Business Associate 2 before the Business Associate 2's receipt of PHI.

AGREEMENT

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 Agreement means DTMB ("Business Associate 1") and Health Services Advisory Group, Inc ("Business Associate 2").

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

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

2. Obligations of Business Associate 2.

Business Associate 2 agrees to:

a. use and disclose PHI only as permitted or required by this Agreement 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 Agreement. Business Associate 2 must maintain, and provide a copy to the Covered Entity and Business Associate 1 within 10 days of a request from the Covered Entity or Business Associate 1, 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 Business Associate 2's operations and the nature and the scope of its activities.

c. report to the Covered Entity and Business Associate 1 within 24 hours of any use or disclosure of PHI not provided for by the Agreement 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 Business Associate 2 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 Business Associate 2 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 Business Associate 2 agree to the same restrictions, conditions, and requirements that apply to Business Associate 2 regarding such information. Each subcontractor must sign an agreement with Business Associate 2 containing substantially the same provisions as this Agreement and further identifying Business Associate 1 and Covered Entity as a third party beneficiary of the agreement with the subcontractor. Business Associate 2 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 Business Associate 2 or its agents or subcontractors, Business Associate 2 must notify the Covered Entity in writing within five days of the request and amend the information within ten days of the request. Any denial of amendment of PHI maintained by Business Associate 2 or its agents or subcontractors is the responsibility of Business Associate 2.

g. maintain, and within ten days of a request from the Covered Entity make available, the information required to provide an accounting of disclosures to enable the Covered Entity to fulfill its obligations under 45 CFR § 164.528. Business Associate 2 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); (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 2 agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate 2 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 written request for disclosure. If the request for an accounting is delivered directly to Business Associate 2 or its agents or subcontractors, Business Associate 2 must, within ten days of the receipt of the request, forward it to the Covered Entity in writing.

h. to the extent Business Associate 2 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 Business Associate 2's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate 2 must concurrently provide to the Covered Entity a copy of any PHI that the Business Associate 2 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 PHI and the hardware and equipment on which it is stored, including but not limited to, removal of PHI before re-use.

l. within ten days of a written request by the Covered Entity, Business Associate 2 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 Agreement. Business Associate 2 and the Covered Entity will mutually agree in advance upon the scope, timing and location of such an inspection. Covered Entity must protect the confidentiality of all confidential and proprietary information of Business Associate 2 to which the Covered Entity has access during the course of such inspection. Covered Entity and Business Associate 2 will 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, Business Associate 2's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate 2 of its responsibility to comply with this Agreement. Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Associate or require 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 Agreement.

3. Permitted Uses and Disclosures by the Business Associate.

a. Business Associate 2 may use or disclose PHI:
(1) for the proper management and administration of Business Associate 2 or to carry out the legal responsibilities of Business Associate 2; provided, however, either (A) the disclosures are required by law, or (B) Business Associate 2 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 Business Associate 2 of any instances of which it is aware in which the confidentiality of the information has been breached;
(2) as required by law;
(3) for Data Aggregation services relating to the health care operations of the Covered Entity;
(4) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If Business Associates 2 de-identifies the PHI it receives from the Covered Entity, Business Associate 2 may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

(5) for any other purpose listed here:

b. Business Associate 2 agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate 2 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:

4. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to Business Associate 2 under this Agreement until the PHI is received by Business Associate 2.
5. provide Business Associate 2 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 Business Associate 2's use or disclosure of PHI.
6. notify Business Associate 2 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 Business Associate 2's use or disclosure of PHI.
7. notify Business Associate 2 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 Business Associate 2's use or disclosure of PHI.

5. Term. This Agreement continues in effect until terminated or is replaced with a new agreement 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 Agreement regarding breach, a breach by Business Associate 2 of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreement and provides grounds for Business Associate 1 to

terminate this Agreement for cause at the request of Covered Entity. Termination for cause is subject to 6.b.:

(1) Default. If Business Associate 2 refuses or fails to timely perform any of the provisions of this Agreement, the Covered Entity may notify Business Associate 2 in writing of the non-performance, and if not corrected within thirty days, Business Associate 1 may immediately terminate the Agreement at the request of Covered Entity. The Business Associate 2 must continue performance of the Agreement to the extent it is not terminated.

(2) Business Associate 2's Duties. Notwithstanding termination of the Agreement, and subject to any directions from the Covered Entity or Business Associate 1, Business Associate 2 must protect and preserve property in the possession of Business Associate 2 in which the Covered Entity has an interest.

(3) Erroneous Termination for Default. If Business Associate 1 terminates this Agreement at the request of Covered Entity under Section 6(a) and after such termination it is determined, for any reason, that Business Associate 2 was not in default, then 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 Agreement had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity or Business Associate 1 knows of a pattern of activity or practice of Business Associate 2 that constitutes a material breach or violation of Business Associate 2's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement under Section 6(a), then the Business Associate 1, at the request of Covered Entity or on its own accord, must notify Business Associate 2 of the pattern of activity or practice. Business Associate 2 must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate 2's efforts to cure such breach or end such violation are unsuccessful, Business Associate 1, at the request of the Covered Entity or on its own accord, may either (i) terminate this Agreement, if feasible or (ii) report Business Associate 2's breach or violation to the Secretary.

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 Business Associate 2 on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for Business Associate 2 to continue its proper management and administration or to carry out its legal responsibilities;
(2) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that Business Associate 2 still maintains in any form;
(3) 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 Business Associate 2 retains the PHI;
(4) not use or disclose the PHI retained by Business Associate 2 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
(5) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by Business Associate 2 when it is no longer needed by Business Associate 2 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. Business Associate 2 has no ownership rights in the PHI. The covered entity retains all ownership rights of the PHI.

9. Disclaimer. Neither Business Associate 1, nor the Covered Entity, warrants or represents that compliance by Business Associate 2 with this Agreement, HIPAA, or the HIPAA Rules will be adequate or satisfactory for Business Associate 2's own purposes. Business Associate 2 is solely responsible for all decisions made by Business Associate 2 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 Business Associate 2's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Covered

Entity the extent to which Business Associate 2's security safeguards comply with HIPAA, the HIPAA Rules or this Agreement.

11. Amendment. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement 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 Agreement 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) one party does not promptly enter into negotiations to amend this Agreement when requested by the other party or (ii) Business Associate 2 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 or the HIPAA Rules.

12. Assistance in Litigation or Administrative Proceedings. Business Associate 2 must make itself, and any subcontractors, employees or agents assisting Business Associate 2 in the performance of its obligations under this Agreement, available to the Covered Entity or Business Associate 1, at no cost to the Covered Entity or Business Associate 1, to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against the Covered Entity or Business Associate 1, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules or other laws relating to Business Associate 2's or its subcontractors use or disclosure of PHI under this Agreement, except where Business Associate 2 or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer upon any person other than the Covered Entity, Business Associate 1, Business Associate 2 and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Interpretation and Order of Precedence. Any ambiguity in this Agreement must be interpreted to permit compliance with the HIPAA Rules. Where the provisions of this Agreement differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement control.

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

16. Survival of Certain Agreement Terms. Notwithstanding any contrary provision in this Agreement, the Business Associate 2's obligations under Section 6(d) and record retention laws ("Effect of Termination") and Section 12 ("No Third Party Beneficiaries") survive termination of this Agreement and are enforceable by the Covered Entity or Business Associate 1.

17. Representatives and Notice.

a. Representatives. The individuals listed below are designated as the parties' respective representatives for purposes of this Agreement. Either party may from time to time designate in writing new or substitute representatives.

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

Covered Entity Representative :

James Bowen
Privacy and Security Manager
MDHHS Compliance Office
333 South Grand Ave, 4th Floor
Lansing, MI 48933
(517) 284-1018
MDHHSPrivacySecurity@michigan.gov

Business Associate 1 Representative:

Name: Pamela Platte
Title: Category Director
Department: Michigan Department of Technology, Management & Budget
Address: 525 W Allegan St, Lansing MI 48933
Phone: 517-249-0927

Email: plattep@michigan.gov

Business Associate 2 Representative:

Name: Mary Ellen Dalton
Title: President and Chief Executive Officer
Department: Health Services Advisory Group, Inc
Address: 3133 East Camelback Road, Suite 100
Phone: Phoenix, AZ 85016
Email: mdalton@hsag.com

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

DTMB as Business Associate 1, on behalf of Michigan Department of Health and Human Services	**Business Associate 2** Health Services Advisory Group, Inc
By:_____	By:_____
Date:_____	Date: _____
Print Name: _____	Print Name:_____
Title:_____	Title:_____