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Comprehensive Health Care Program for the Michigan

Department of Health and Human Services

Contract No.

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STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and [Insert Company Name] ("**Contractor**"), a [Insert State & Entity Status, e.g., a Michigan corporation or a Texas limited liability company]. This Contract is effective on October 1, 2024 ("**Effective Date**"), and unless terminated, will expire on September 30, 2029 (the "**Term**").

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 (the "**Contract Activities**") described in a Statement of Work; the initial Statement of Work is attached as Schedule A – Statement of Work. 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 unless otherwise specified in a Statement of Work.

   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) 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; (i) comply with all State physical and IT security policies and standards which will be made available upon request; and (j) 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:
See Contract Administrator information shown below.	[Name] [Street Address] [City, State, Zip] [Email] [Phone]

3. **Contract Administrator.** The Contract Administrator, or the individual duly authorized 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:
Marissa Gove **320 S. Walnut St. 2nd Floor** **Lansing, MI 48909-7526** **Govem1@michigan.gov** **(517) 449-8952**	[Name] [Street Address] [City, State, Zip] [Email] [Phone]

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:
Jennifer Therrien **Michigan Department of Health & Human Services** **400 South Pine** **Lansing, MI 48933** **Therrienj1@michigan.gov** **(517) 284-1145**	[Name] [Street Address] [City, State, Zip] [Email] [Phone]

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

6. **Insurance Requirements. See Schedule C.**

7. **Reserved.**

8. **Reserved.**

9. **Relationship of the Parties.** The relationship between the parties is that of independent contractors. 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. Neither party has authority to contract for nor bind the other party in any manner whatsoever.

10. **Intellectual Property Rights.** If a Statement of Work requires Contractor to create any intellectual property, 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.

11. **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.

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

13. **Key Personnel.** 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.

    a. 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 Project 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.

    b. 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 the **Termination for Cause** section of the Standard Contract 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.

    c. 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.

14. **Background Checks.** Upon request, or as may be specified in a Statement of Work, 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.

15. **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.

16. **Change of Control.** Contractor will notify the State, within 30 days of any public announcement or otherwise once legally permitted to do so, 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.

17. **Ordering.** Contractor is not authorized to begin performance until receipt of authorization as identified in a Statement of Work.

18. **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 a Statement of Work. 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 25, 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.

19. **Reserved.**

20. **Reserved.**

21. **Reserved.**

22. **Payment.** Contractor will receive payment through the CHAMPS system at the rate set forth in Appendix 22.

    The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use. Notwithstanding the foregoing, all fees 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.

23. **Liquidated Damages or Monetary Sanctions.** Liquidated damages or Monetary sanctions, if applicable, will be assessed as described in a Statement of Work. The parties understand and agree that any liquidated damages or monetary sanctions (which includes but is not limited to applicable credits) set forth in this Contract are reasonable estimates of the State's damages in accordance with applicable law. The parties acknowledge and agree that Contractor could incur liquidated damages or monetary sanctions for more than 1 event. The assessment of liquidated damages or monetary sanctions will not constitute a waiver or release of any other remedy the State may have under this Contract for Contractor's breach of this Contract, including without limitation, the State's right to terminate this Contract for cause under Section 25 and the State will be entitled in its discretion to recover actual damages caused by Contractor's failure to perform its obligations under this Contract. Amounts due the State as liquidated damages or monetary sanctions may be set off against any fees payable to Contractor under this Contract, or the State may bill Contractor as a separate item and Contractor will promptly make payments on such bills.

24. **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.

25. **Termination for Cause.** (a) The State may terminate this Contract for cause, in whole or in part, if Contractor, as determined by the State: (i) endangers the value, integrity, or security of any facility, data, or personnel; (ii) becomes insolvent, petitions for bankruptcy court proceedings, or has an involuntary bankruptcy proceeding filed against it by any creditor; (iii) engages in any conduct that may expose the State to liability; (iv) breaches any of its material duties or obligations under this Contract; or (v) fails to cure a breach within the time stated by the State in a notice of breach, if in its sole discretion the State has chosen to provide a time to cure. Any reference to specific breaches being material breaches within this Contract will not be construed to mean that other breaches are not material.

    (b) If the State terminates this Contract under this Section, the State will issue a termination notice specifying whether Contractor must: (i) cease performance immediately. Contractor must submit all invoices for Contract Activities accepted by the State within 30 days of the date of termination. Failure to submit an invoice within that timeframe will constitute a waiver by Contractor for any amounts due to Contactor for Contract Activities accepted by the State under this Contract or (ii) 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 26, 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. Contractor must promptly reimburse to the State any fees prepaid by the State prorated to the date of such termination, including any prepaid fees. 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.

Termination for Convenience. The State may immediately terminate this Contract in whole or in part without penalty and for any reason or no 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. Contractor must submit all invoices for Contract Activities accepted by the State within 30 days of the date of termination. Failure to submit an invoice within that timeframe will constitute a waiver by Contractor for any amounts due Contractor for Contract Activities accepted by the State under this Contract, or (b) continue to perform the Contract Activities in accordance with Section 27, 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 to the extent the funds are available.

26. **Transition Responsibilities.** Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed two years), provide all reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees. Such transition assistance may include, but is not limited to: (a) continuing to perform the Contract Activities at the established Contract rates; (b) taking all reasonable and necessary measures to transition performance of the work, including all applicable Contract Activities, training, equipment, software, leases, reports and other documentation, to the State or the State's designee; (c) 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 (d) 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.

27. **Return of State Property.** Upon termination or expiration of this Contract for any reason, Contractor must take 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 the Contractor by any entity, agent, vendor, or employee of the State.

28. **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, at its own cost and expense, if the State deems necessary. Contractor will not, without the State's prior 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.

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.

The State is constitutionally prohibited from indemnifying Contractor or any third parties.

29. **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.

30. **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 FIVE MILLION DOLLARS.** The State is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

31. **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 (3) any complaint filed in a legal or administrative proceeding alleging the Contractor or its subcontractors discriminated against its employees, subcontractors, vendors, or suppliers during the term of this Contract; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

32. **Reserved.**

33. **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, user data, and any other 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) protected 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.

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; (c) keep and maintain State Data in the continental United States and (d) not use, sell, rent, transfer, distribute, commercially exploit, 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. Contractor's misuse of State Data may violate state or federal laws, including but not limited to MCL 752.795.

c. Extraction of State Data. Contractor must, within 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 a Statement of Work, Contractor is responsible for maintaining a backup of State Data and for an orderly and timely recovery of such data. Unless otherwise described in a Statement of Work, Contractor must maintain a contemporaneous backup of State Data that can be recovered within 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 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 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 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 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 34** are to be considered direct damages and not consequential damages.

34. **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.

   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; or, (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 or is: (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, though, 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.

35. **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.

36. **Reserved.**

37. **Reserved.**

38. **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 records related to the Contract through the term of the Contract and for 10 years after the latter of termination, expiration, or final payment under this Contract or any extension ("**Audit Period**"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

Within 10 calendar days of providing notice, the State and its authorized representatives or designees have the right to enter and inspect Contractor's premises or any other places where Contract Activities are being performed, and examine, copy, and audit all records related to this Contract. Contractor must cooperate and provide reasonable assistance. If 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.

39. **Representations and Warranties.** 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 25, Termination for Cause.

40. **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.

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

42. **Reserved.**

43. **Reserved.**

44. **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.

45. **Unfair Labor Practice.** Under MCL 423.324, the State may void this Contract if the name of the Contractor, or the name of a subcontractor, manufacturer, or supplier of the Contractor, subsequently appears on the Unfair Labor Practice register compiled under MCL 423.322.

46. **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 the Michigan Court of Claims. Contractor waives any objections, such as lack of personal jurisdiction or *forum non conveniens*. Contractor must appoint an agent in Michigan to receive service of process.

47. **Non-Exclusivity.** Nothing contained in this Contract is intended nor is to be construed as creating any requirements contract with Contractor, nor does it provide Contractor with a right of first refusal for any future work. This Contract does not restrict the State or its agencies from acquiring similar, equal, or like Contract Activities from other sources.

48. **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.

49. **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.

50. **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 the prior written approval of the State, and then only in accordance with the explicit written instructions of the State.

51. **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:

Document Title	Document Description
Schedule A	Statement of Work
Schedule B	Reserved
Schedule C	Insurance Requirements
Schedule E	Data Security Requirements
Schedule K	Subcontractor Information Template
Standard Contract Terms	Provides legal terms for the contract

Federal Provisions Addendum	The document provides federally required provisions when federal funds are used for the procurement.

52. **Entire Agreement and Order of Precedence.** This Contract, which includes Statement of Work, and schedules and exhibits, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, this Contract, excluding its schedules, exhibits, and Statement of Work; (b) second, 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, OR DOCUMENTATION HEREUNDER, EVEN IF ATTACHED TO THE STATE'S DELIVERY OR PURCHASE ORDER, WILL CONSTITUTE A PART OR AMENDMENT OF THIS CONTRACT OR IS BINDING ON THE STATE OR ANY AUTHORIZED USER FOR ANY PURPOSE. ALL SUCH OTHER TERMS AND CONDITIONS HAVE NO FORCE AND EFFECT AND ARE DEEMED REJECTED BY THE STATE AND THE AUTHORIZED USER, EVEN IF ACCESS TO OR USE OF THE CONTRACT ACTIVITIES REQUIRES AFFIRMATIVE ACCEPTANCE OF SUCH TERMS AND CONDITIONS.

53. **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.

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

55. **Survival.** Any right, obligation or condition that, by its express terms or nature and context is intended to survive, will survive the termination or expiration of this Contract; such rights, obligations, or conditions include, but are not limited to, those related to transition responsibilities; indemnification; disclaimer of damages and limitations of liability; State Data; non-disclosure of Confidential Information; representations and warranties; insurance and bankruptcy.

56. **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

This addendum applies to purchases that will be paid for in whole or in part with funds obtained from the federal government. The provisions below are required, and the language is not negotiable. Contractor agrees to comply with all obligations under federal rules or regulations for such funding, including but not limited to the provisions contained in this addendum. If any provision below conflicts with the State's terms and conditions, including any attachments, schedules, or exhibits to this 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. Further, Contractor agrees to, through a Contract Change Notice, append or modify specific federal provisions to this Contract, if reasonably necessary to keep the State and Contractor in compliance with federal funding requirements, and comply with the terms set forth therein. Hyperlinks are provided for convenience only; broken hyperlinks will not relieve Contractor from compliance with the law.

A. Equal Employment Opportunity

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3.

B. Davis-Bacon Act (Prevailing Wage)

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3, nor is it a prime construction contract in excess of $2,000.

C. Copeland "Anti-Kickback" Act

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3, nor is it a prime construction contract in excess of $2,000 where the Davis-Bacon Act applies.

D. Contract Work Hours and Safety Standards Act

The Contract does not involve the employment of mechanics or laborers.

(1)

E. Rights to Inventions Made Under a Contract or Agreement

If this 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.

F. Clean Air Act and the Federal Water Pollution Control 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), and during performance of this Contract the Contractor agrees as follows:

(1) Clean Air Act

(i) The Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.

(ii) The Contractor agrees to report each violation to the State and understands and agrees that the State will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency or the applicable federal awarding agency, and the appropriate Environmental Protection Agency Regional Office.

(iii) The Contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA or the

applicable federal awarding agency.

(2) Federal Water Pollution Control Act

(i) The Contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.

(ii) The Contractor agrees to report each violation to the State and understands and agrees that the State will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency or the applicable federal awarding agency, and the appropriate Environmental Protection Agency Regional Office.

(iii) The Contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA or the applicable federal awarding agency.

G. 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 (51 FR 6370; February 21, 1986) and 12689 (54 FR 34131; August 18, 1989), "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.

(1) This Contract is a covered transaction for purposes of 2 C.F.R. Part 180 and 2 C.F.R. Part 3000. As such, the Contractor is required to verify that none of the Contractor's principals (defined at 2 C.F.R. § 180.995) or its affiliates (defined at 2 C.F.R. § 180.905) are excluded (defined at 2 C.F.R. § 180.940) or disqualified (defined at 2 C.F.R. § 180.935).

(2) The Contractor must comply with 2 C.F.R. Part 180, subpart C and 2 C.F.R. Part 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction it enters into.

(3) This certification is a material representation of fact relied upon by the State. If it is later determined that the contractor did not comply with 2 C.F.R. Part. 180, subpart C and 2 C.F.R. Part. 3000, subpart C, in addition to remedies available to the State, the Federal Government may pursue available remedies, including but not limited to suspension and/or debarment.

(4) The bidder or proposer agrees to comply with the requirements of 2 C.F.R. Part 180, subpart C and 2 C.F.R. Part 3000, subpart C while this offer is valid and throughout the period of any contract that may arise from this offer. The bidder or proposer further agrees to include a provision requiring such compliance in its lower tier covered transactions.

H. Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended)

Contractor has applied or bid for an award of **more than $100,000** and shall file the required certification in *Exhibit 1 – Byrd Anti-Lobbying Certification* attached to the end of this Addendum. Each tier certifies to the tier above that it will not and has not used federally appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, officer or employee of Congress, or an employee of a Member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to the recipient who in turn will forward the certification(s) to the federal awarding agency.

I. Procurement of Recovered Materials

If this Contract is a procurement to purchase products or items designated by the EPA under 40 C.F.R. part

247 during the course of a fiscal year, then under 2 CFR 200.323, Contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act.

(1) In the performance of this contract, the Contractor shall make maximum use of products containing recovered materials that are EPA-designated items unless the product cannot be acquired:
   (i) Competitively within a timeframe providing for compliance with the contract performance schedule;
   (ii) Meeting contract performance requirements; or
   (iii) At a reasonable price.

(2) Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg-program.

(3) The Contractor also agrees to comply with all other applicable requirements of Section 6002 of the Solid Waste Disposal Act.

J. Prohibition on Contracting for Covered Telecommunications Equipment or Services

Contractor acknowledges and agrees that Section 889(b) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019, Pub. L. No. 115-232 (the "McCain Act"), and 2 C.F.R. §200.216, prohibit the obligation or expending of federal award funds on certain telecommunication products or with certain entities for national security reasons on or after August 13, 2020.

During performance of this Contract, the Contractor agrees as follows:

(a) *Definitions.* As used in this Section J. Prohibition on Contracting for Covered Telecommunications Equipment or Services ("Section J"):
   (1) the terms "backhaul," "critical technology," "interconnection arrangements," "reasonable inquiry," "roaming," and "substantial or essential component" have the meanings defined in 48 CFR § 4.2101;
   (2) the term "covered foreign country" has the meanings defined in § 889(f)(2) of the McCain Act; and
   (3) the term "covered telecommunications equipment or services" has the meaning defined in § 889(f)(3) of the McCain Act.

(b) *Prohibitions*.
   (1) Unless an exception in paragraph (c) of this Section J applies, neither the Contractor nor any of its subcontractors may use funds received under this Contract to:
      (i) Procure or obtain any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology of any system;
      (ii) Enter into, extend, or renew a contract to procure or obtain any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology of any system;
      (iii) Enter into, extend, or renew a contract with an entity that uses any covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system; or
      (iv) Provide, as part of its performance of this contract, subcontract, or other contractual instrument, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system.

(c) *Exceptions*.

(1) This Section J does not prohibit Contractor from providing—

(i) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(ii) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) *Reporting requirement*.

(1) In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this Section J to the recipient or subrecipient, unless elsewhere in this contract are established procedures for reporting the information.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this Section J:

(i) Within one business day from the date of such identification or notification: The contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this Section J: Any further available information about mitigation actions undertaken or recommended. In addition, the contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts.* The Contractor shall insert the substance of this Section J, including this paragraph (e), in all subcontracts and other contractual instruments.

K. Domestic Preferences for Procurements

As appropriate, and to the extent consistent with law, the Contractor should, to the greatest extent practicable, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States. This includes, but is not limited to iron, aluminum, steel, cement, and other manufactured products.

For purposes of this Section K – **Domestic Preferences for Procurements**:

"Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
"Manufactured products" mean items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

L. Affirmative Socioeconomic Steps

For all contracts utilizing federal funding sources subject to Title 2 of the Code of Federal Regulations (C.F.R.) Part 200 issued on or after November 12, 2020, if subcontracts are to be let, the prime contractor is required to take all necessary steps identified in 2 C.F.R. § 200.321(b)(1)-(5) to ensure that small and minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

M. Copyright and Data Rights

Pursuant to 2 CFR § 200.315(b), the State may copyright any work which is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The Federal awarding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

N. Additional FEMA Contract Provisions

This Contract does not involve purchases that will be paid for in whole or in part with funds obtained from the Federal Emergency Management Agency (FEMA).

O. Other Federal Contract Provisions

The following provisions also apply to purchases that will be paid for in whole or in part with funds obtained from the federal government: Contractor must comply with federal requirements in Title XIX of the Social Security Act, 42 CFR Part 438 and other applicable laws, including requirements incorporated into the Medicaid and Children's Health Insurance Program Managed Care Final Rule published November 13, 2020 and effective on December 14, 2020, and requirements in effect prior to the release of the 2020 Final Rule (i.e., in effect in 42 CFR Part 438 contained in 42 CFR Parts 430 to 481, edition revised as of May 6, 2016) and did not materially change within the 2020 Final Rule.

EXHIBIT 1
BYRD ANTI-LOBBYING CERTIFICATION

Contractor must complete this certification if the purchase will be paid for in whole or in part with funds obtained from the federal government and the purchase is greater than $100,000.

APPENDIX A, 44 C.F.R. PART 18 – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress 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.

2. If any funds other than 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 in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. C. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SCHEDULE A- STATEMENT OF WORK

Contract No.

Comprehensive Health Care Program for the Michigan

Department of Health and Human Services

STATEMENT OF WORK CONTRACT ACTIVITIES

This schedule identifies the requirements of this Contract

BACKGROUND

MDHHS is focused on improving the lives of Enrollees through its contracts with Medicaid Health Plans (MHPs). In preparation for the 2023 CHCP procurement, under the banner of MIHealthyLife, MDHHS sought stakeholder input on how to create a more equitable, coordinated, and person-centered system of care, dedicated to ensuring Michiganders a healthier future. MDHHS received input from people enrolled in Medicaid and their families, advocacy groups, Community-based Organizations, health systems and other providers, health plans and other interested parties. After hearing from nearly 10,000 respondents, MDHHS identified several focus areas, or strategic pillars, that serve as the foundation for this MHP contract:

- **Serve the Whole Person, Coordinating Health and Health-Related Needs:** MHPs must ensure adequate access to high quality physical health services, dental care, behavioral health services, as well as services that address Health Related Social Needs, serving as a bridge across programs that have traditionally operated independently, including but not limited to the Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Local Health Departments (LHDs), and with Community-based Organizations (CBOs), By serving the 'Whole Person', MHPs must focus on improving the overall health and wellbeing of all Enrollees.
- **Give All Kids a Healthy Start:** MHPs must ensure access to preventive care, including but not limited to well-visits, screenings and vaccines, for child and adolescent Enrollees. MHPs must also improve health for mothers and their babies, reducing differences or disparities in health outcomes.
- **Promote Health Equity and Reduce Racial and Ethnic Disparities:** MHPs must provide culturally and linguistically appropriate services to their Enrollees and integrate consideration of health equity across their initiatives, including but not limited to their value-based payment programs and accreditation. MHPs must seek to identify and mitigate inequities in birth outcomes, including maternal morbidity and mortality, through their maternal health programs. Enrollees must be meaningfully engaged in the development and implementation of health equity initiatives.
- **Drive Innovation and Operational Excellence:** MHPs must be accountable to *all* contractual responsibilities—such as ensuring adequate and timely access to all Covered Services, coordinating services covered outside this Contract, improving quality of care delivered to Enrollees, streamlining administrative processes, where possible, and complying with MDHHS policies, guidance and requests. MHPs must work with the state on efforts to align MHP innovation with state-identified priorities.
- **Engage Members, Families and Communities:** MHPs must work with Enrollees and their families to engage them in the care coordination and delivery process and ensure care is patient-centered.

Through this procurement, MDHHS seeks contractors with the experience, capabilities and commitment to

advance these strategic pillars, and, ultimately, improve the health of Michiganders entrusted in their care.

SCOPE

This is a Contract to obtain the services of one or more Contractors to provide Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan, as described herein. This is a unit price-per member per month (PMPM) Capitated Rate Contract. Medicaid beneficiaries must have a choice among Contractors. Therefore, the State cannot guarantee a specific number of Enrollees to any Contractor. The Contractor must employ a population health management approach in all programs and interventions delivered to Medicaid beneficiaries.

Definitions
Contract definitions are provided at the end of Schedule A.

Note
Remedies, Sanctions, or liquidated damages described in Schedule A are in addition to, and not in lieu of, the State's ability to terminate this Contract pursuant to the Contract terms. Requirements outlined in Schedule A are in addition to, and not in lieu of, any requirements set forth elsewhere in this Contract.

1. Specifications

1.1 Contractor Requirements

Contractor must provide Deliverables and staff, and otherwise do all things necessary for or incidental to the requirements and performance of work, pursuant to the requirements set forth in this Contract. The requirements set forth in Schedule A and elsewhere in the Contract may collectively be referred to as “Contract Activities.” Contractor must comply with all provisions of Medicaid Policy applicable to Contractors unless provisions of this Contract stipulate otherwise. All policies, procedures, operational plans, and clinical guidelines followed by the Contractor must be in writing and available to MDHHS and Centers for Medicare and Medicaid Services (CMS) upon request. All medical records, report formats, information systems, liability policies, Provider Network information and other detail specific to performing the contracted services must be available to MDHHS and CMS upon request.

I. Service Area

A. Regions

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

1. Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft
2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon
4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm,

Newaygo, Oceana, Osceola, Ottawa

5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
7. Clinton, Eaton, Ingham
8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
10. Macomb, Oakland, Wayne

B. Service Area Expansion during Contract Term

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

C. Contiguous County Service Areas

Contractor may provide services in their Contracted Service Area through the use of Network Providers in contiguous counties outside their Contracted Service Area, subject to MDHHS approval. Contractor must provide a complete description of the Provider Network, including the identification of the contiguous counties with an available Network Provider and the counties in the Region to be served through this Network Provider.

D. Exception for Rural Area Residents

The exception for Rural Area Residents (42 CFR 438.52(b)(1)) from the requirement that a choice of at least two managed care entities be available for beneficiaries mandatorily enrolled in managed care is currently in effect in Region 1, the 15 counties in the region that comprises Michigan's Upper Peninsula.

1. Medicaid beneficiaries who reside in Region 1 are mandatorily enrolled with a single Contractor permitted;
    a. Enrollees have a choice between at least two Primary Care Providers (PCP).
        i. Contractor may not limit an Enrollee's freedom to change between PCPs without cause in a manner that is more restrictive than the limitations that apply to Enrollee disenrollment from a MHP under this Contract.
    b. Enrollees have the option of obtaining services from any other Network or non- Network Provider if the following conditions exist:
        i. The Covered Service, practitioner, or specialist is not available within the Contractor's network.
        ii. The provider is not part of the network but is the main source of a service to the Enrollee.
        iii. The only provider available to the Enrollee does not, because of moral or religious objections, provide the service the Enrollee seeks.

iv. Related services must be performed by the same provider and all of the services are not available within the Network.

v. MDHHS determines other circumstances that warrant Out-of-Network treatment.

11. MDHHS may implement the exception for Rural Area Residents in other regions during the course of this Contract if necessary, to accommodate enrollment, Contractors leaving the Service Area, or other factors.

12. Michigan counties for which the State has federal approval to implement an exception for Rural Area Residents are listed in Appendix 1 of this Contract.

II. Medicaid Eligibility and CHCP Enrollment Groups

A. Medicaid Eligibility

The Behavioral and Physical Health and Aging Services Administration (BPHASA) administers the Medicaid program in Michigan. Eligibility is determined by the State with the sole authority to determine whether individuals or families meet eligibility requirements as specified for enrollment in the CHCP and other State assistance programs.

B. Children's Special Health Care Services (CSHCS) Eligibility

Eligibility for CSHCS (authorized by Title V of the Social Security Act; see DEFINITIONS for additional detail) is determined by the State with the sole authority to determine whether individuals meet eligibility requirements. Individuals eligible for both CSHCS and Medicaid are a mandatorily enrolled Medicaid Eligible Group (See Section 1.1.II.C.1.c).

1. Contractor must follow MDHHS procedures and provide any necessary information for the determination of CSHCS eligibility and must begin the redetermination process of CSHCS Enrollees at least six months prior to the benefit plan end date. This includes obtaining required medical reports for subspecialist providers.

2. Contractor or admitting hospital must submit a completed Medical Eligibility Referral Form (MERF) to MDHHS within 30 Days of hospital admission or Contractor's receipt of notification of the eligible condition for MDHHS to determine medical eligibility:

   a. When complete medical documentation meeting the guidelines specified by MDHHS is not available within the 30-Days timeframe, the Contractor must submit the MERF and all required medical documentation within 10 Days after the information becomes available.

   b. Contractor must notify the Enrollee in a timely manner when submitting the MERF to MDHHS.

   c. Contractor must utilize the MDHHS procedures for MERF submission if there is any indication additional CSHCS-qualifying diagnoses (see DEFINITIONS for reference to diagnoses) may be present.

C. Medicaid Eligible Groups

Within the Medicaid eligible population, there are groups enrolled in the CHCP mandatorily, groups who may enroll in the CHCP voluntarily, and groups excluded from enrollment in the CHCP. Medicaid eligible groups are defined by Federal Regulations Title 42 Chapter IV Subchapter C Part 435 Subparts B, C, and D:

1. Medicaid Eligible Groups Mandatorily Enrolled in the CHCP:
    a. Children in foster care
    b. Families with children receiving assistance under the Financial Independence Program (FIP)
    c. Persons enrolled in Children's Special Health Care Services (CSHCS)
    d. Persons under age 21 who are receiving Medicaid
    e. Persons Enrolled in the MIChild Program
    f. Persons receiving Medicaid for the aged
    g. Persons receiving Medicaid for the blind or disabled
    h. Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
    i. Pregnant Women
    j. Medicaid eligible persons enrolled under the Healthy Michigan Plan (HMP)
    k. Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
    a. Migrants
    b. American Indian/Alaska Native
    c. Persons with both Medicare and Medicaid eligibility
3. Medicaid Eligible Groups Excluded from Enrollment in the CHCP:
    a. Children in Child Care Institutions
    b. Deductible clients (also known as spenddown)
    c. Persons without full Medicaid coverage
    d. Persons with Medicaid who reside in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID) or a State psychiatric hospital
    e. Persons receiving long term care (custodial care) in a nursing facility
    f. Persons authorized to receive private duty nursing services
    g. Persons being served under the Home & Community Based Elderly Waiver
    h. Persons with commercial HMO/PPO coverage
    i. Persons in PACE (Program for All-inclusive Care for the Elderly)
    j. Persons in the Refugee Assistance Program
    k. Persons in the Repatriate Assistance Program
    l. Persons in the Traumatic Brain Injury Program
    m. Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula

n. Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
o. Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan
p. Persons incarcerated in a city, county, state, or federal correctional facility
q. Persons participating in the MI Health Link Demonstration

D. Benefits Monitoring Program

1. Contractor must utilize a systematic method for the identification of Enrollees who meet the criteria for the Benefits Monitoring Program (BMP) under Medicaid policy.

2. Contractor must utilize the BMP- Program Monitoring (PROM) application for the identification of BMP candidates.

3. Upon determination of BMP enrollment, the Contractor must notify the Enrollee that she/he will be placed in the BMP and provide an effective date of no less than 12 Days after notification.

4. Upon determination of BMP enrollment, the Contractor must assign a Provider and/or a pharmacy to the Enrollee. Contractor must notify the Enrollee of this assignment and provide an effective date of no less than 12 Days after notification.

5. Contractor must participate in MDHHS Fair Hearings that result if the Enrollee Appeals any Adverse Action while the Enrollee is in BMP.

6. Upon enrollment in the BMP, the Contractor must provide education to the Enrollee on the correct utilization of services.

7. Contractor must assist the Enrollee to remove barriers to the Enrollee's correct utilization of services and make the appropriate referrals to mental health and substance use disorder providers when appropriate.

8. Contractor must systematically monitor the Enrollee's utilization of services to determine whether the enrollment in BMP and education have modified the Enrollee's behavior.

9. Contractor must establish timelines consistent with Medicaid policy for the review of each Enrollee in BMP to determine if the Enrollee has met goals and guidelines and may be removed from BMP.

10. All remedies and sanctions must be allowed by Medicaid policy and State and federal law. Prior to implementing new remedies and sanctions, the Contractor must obtain written approval from MDHHS.

III. Payment Reform

A. Value-Based Payment Models

1. Consistent with MDHHS's policy to move reimbursement from fee-for-service (FFS) to value-based payment models, Contractor must increase the total percentage of health care services reimbursed under value-based contracts

over the term of the agreement. The Contractor must ensure that a minimum of 50% of health care service reimbursement is under value-based contracts in categories 2C, 3, and 4 of the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework, that a minimum of 12.5% of health care service reimbursement is under value-based contracts in LAN categories 3 and 4 of the APM Framework, and that a minimum of 2.5% of health care services reimbursement is made based on a provider incentive under value-based contracts for the fiscal year 2025 reporting period.

2. Contractor recognizes value-based payment models as those that reward Providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Contractor recognizes the importance of establishing value-based payment models that improve health equity and do not further exacerbate health disparities. Value-based payment models include, but are not limited to:

    a. Total Capitation models
    b. Limited Capitation models
    c. Bundled payments or Episode of Care models
    d. Supplemental payments to build practice-based infrastructure and Enrollee management capabilities.
    e. Value-based payment models may also include payment for new services that promote more coordinated and appropriate care, such as care management and community health work services or other services that may not be traditionally reimbursable.

3. As directed in Appendix 3, Contractor will report to MDHHS on MHP health care service reimbursement under value-based contracts using the format specified by MDHHS in Appendix 5F and will comply with payment reform goals and threshold targets established by MDHHS in consultation with contracted MHPs.

4. Contractor in accordance with timeliness requirements outlined in Appendix 3 must submit its APM Reports including:

    a. Semi-Annual APM Progress Report
    b. APM Data Collection Tool
    c. APM Quality Impact Analysis

B. Patient-Centered Medical Homes

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

2. Contractor must contract with providers in their network to provide care management and care coordination services to their members.

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

4. Contractor must coordinate health plan care management activities with practice care management activities, including those to address Health Related Social Needs.

5. Contractor must utilize the PCMH model within their APM strategy consistent with Appendix 5F.

    a. Contractor Must Use a Defined and Uniform Set of Measures for Value-Based Payment Models for PCMHs.

        i. In any value-based payment contract with PCMHs starting no later than Contract Year 2, Contractor must include a uniform set of performance measures established by MDHHS.

        ii. Contractor may add no more than three performance measures of its choosing in addition to the MDHHS-defined set of uniform measures to its value-based payment contracts with PCMHs.

        iii. MDHHS will provide the Contractor with the defined and uniform set of measure prior to Contract Year 1. Contractor agrees to comply with the uniform measure set requirements pursuant to forthcoming MDHHS guidance.

        iv. As requested by MDHHS, the Contractor must participate in initiatives to develop the Defined and Uniform Set of Measures for Value-Based Payment Models for PCMHs.

C. Mental Health Integration

1. Contractor recognizes the importance of integrating both physical health and mental health services in order to effectively serve the whole person, address Enrollee needs and improve health status.

2. Contractor must work with MDHHS to develop and implement initiatives to:

    a. Better coordinate services covered by Contractor and the Prepaid Inpatient Health Plan(s) (PIHP) serving Contractor's Enrollees, and

    b. Provide incentives to support mental health integration at the clinical level.

3. Contractor must work with PIHPs and MDHHS to report on MDHHS-defined shared metrics that seek to measure the quality of care provided to Enrollees jointly served by the Contractor and PIHPs. These shared metrics are included in Appendix 5E.

D. Data Reporting

1. In order to continually improve the performance of its contracted Providers, Contractor must collect and report data in a consistent and coordinated manner in collaboration with MDHHS.

2. Contractor agrees to work collaboratively with MDHHS and with other Contractors to develop standard measure specifications, data collection processes, baseline data, and reports that will be provided to contracted Providers and MDHHS.

IV. CHCP Enrollment and Disenrollment

A. Enrollment Discrimination Prohibited

1. Contractor must not discriminate against individuals eligible to enroll on the basis of:

   a. Health status or the need for health services

   b. Race, color, national origin, age, disability, sex, sexual orientation, gender identity or other factors identified in 42 CFR 438.3(d) and will not use any policy or practice that has the effect of discriminating as such.

2. Contractor must accept Enrollees for enrollment in the order in which they apply without restriction.

B. Enrollment Services Contractor

MDHHS contracts with an Enrollment Services Contractor to contact and educate Medicaid beneficiaries regarding managed care and assist beneficiaries to enroll, disenroll, and change enrollment with their Contractor. Because MDHHS holds the contract with the Enrollment Services Contractor, this Contract may reference MDHHS and by extension the Enrollment Services Contractor as directed by MDHHS.

C. Initial Enrollment and Automatic Reenrollment

1. Contractor must accept as enrolled all beneficiaries listed on all HIPAA-compliant enrollment files/reports and infants enrolled by virtue of the mother's enrollment status (see Section 1.1.IV.D.1).

2. Enrollees disenrolled from the Contractor due to loss of Medicaid eligibility or other action will be retroactively reenrolled to the same Contractor automatically, provided eligibility is regained within two months.

D. Newborn Enrollment

1. Newborns will be automatically enrolled with the mother's Contractor at the time of birth.

2. Contractors will receive a full Capitation Payment for the month of birth.

3. Contractor must reconcile their birth records with the enrollment information supplied by MDHHS.

4. Contractors must submit a newborn service request to MDHHS no later than six months following the month for which the

Contractor has a record of birth if:

a. MDHHS has not notified the Contractor of an Enrollee birth for two months or more following the month for which the Contractor has a record of birth.

b. The child is born outside Michigan.

5. Newborn service request must include newborn's first and last name, sex, and date of birth, at a minimum, in addition to the Medicaid identification number when present.

E. Auto-Assignment of Beneficiaries

1. Beneficiaries who do not select a health plan within the allotted time period will be automatically assigned to a Contractor based on the Contractor's network capacity to accept new Enrollees and performance in areas specified by MDHHS (e.g., quality metrics).

2. MDHHS will automatically assign a larger proportion of beneficiaries to the highest performing Contractors. Members of a family unit will be assigned together whenever possible.

3. MDHHS has the sole authority for determining the methodology and criteria used for auto-assignment of beneficiaries.

F. Enrollment Lock-In and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions

Except as stated in this subsection, enrollment with the Contractor will be for a period of 12 months with the following conditions:

1. Sixty Days prior to each Enrollee's annual open enrollment period, MDHHS will notify Enrollees of their right to disenroll with their current Contractor and reenroll with another Contractor.

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

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

4. Enrollees who choose to remain with the same Contractor will be deemed to have had their opportunity for disenrollment without cause declined until the next open enrollment period.

5. New Enrollees or Enrollees who change from one Contractor to another will have 90 Days from the enrollment begin date with the Contractor or during the 90 Days following notification of enrollment, whichever is later, to change Contractors without cause.

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

G. Enrollment Effective Date

1. Contractor must provide Covered Services and coordination for services to Enrollees until their date of disenrollment. Changes in enrollment will be approved and implemented by MDHHS on a calendar month basis unless the Contractor is notified of a mid-month disenrollment on the daily enrollment file.

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

3. With the exception of newborns and children enrolled in foster care, when an individual is determined to be Medicaid eligible, enrollment with a Contractor will occur on the first day of the next available month following the eligibility determination and enrollment process. Only full month Capitation Payments will be made to the Contractor.

4. With the exception of newborns and children enrolled in foster care, the Contractor will not be responsible for paying for health care services during a period of retroactive eligibility prior to the date of enrollment with the Contractor.

5. If the Beneficiary is in any inpatient hospital setting on the date of enrollment (first day of the month) Contractor will not be responsible for the inpatient stay or any charges incurred prior to the date of discharge. Contractor must be responsible for all care from the date of discharge forward.

6. If an Enrollee is disenrolled from a Contractor and is in any inpatient hospital setting on the date of disenrollment (last day of the month) the Contractor must be responsible for all charges incurred through the date of discharge.

7. If an Enrollee becomes eligible for CSHCS, the effective date of enrollment in the CSHCS benefit plan is:

    a. The first day of the month of the child's admission to a facility during which the eligible condition was identified by a pediatric subspecialist, or

    b. If the child was not admitted to a facility when the eligible condition was identified, the first day of the month that eligible condition was identified by a pediatric subspecialist and services for the condition were provided.

H. Enrollment Errors by MDHHS

1. If a non-eligible individual or a Medicaid Beneficiary who resides outside the Contractor's Service Area is enrolled with the Contractor and MDHHS is notified within 15 Days of enrollment effective date, MDHHS will retroactively disenroll the individual and recoup the Capitation Payment from the Contractor. Contractor may recoup payments from its Providers as allowed by Medicaid Policy and Contractor's Provider Contracts. (Note: If MDHHS does not recoup the Capitation Payment, Contractor must not recoup payments to providers.)

2. With the exception of newborns, if a non-eligible individual is enrolled with a Contractor, and MDHHS is notified after 15 Days of enrollment effective date, MDHHS will disenroll the Enrollee prospectively the first day of the next available Month.

3. If a Beneficiary is disenrolled due to retroactive loss of eligibility in error, MDHHS will confirm if Contractor received a capitation payment for the time period. If so, and Beneficiary is still mandatory or voluntary for Managed Care, MDHHS will send a

replacement enrollment to the Contractor when the eligibility is corrected. The replacement enrollment will have a retroactive date but is not a retroactive enrollment.

I. Disenrollment Discrimination Prohibited

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

2. Contractor may not request disenrollment because of an Enrollee's:

   a. Adverse change in physical or mental health status

   b. Utilization of medical services

   c. Diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs (except when their continued enrollment seriously impairs the entity's ability to furnish services to either this particular Enrollee or other Enrollees.)

J. Special Disenrollments

1. Contractor may initiate special disenrollment requests to MDHHS if the Enrollee acts in a violent or threatening manner not resulting from the Enrollee's special needs as prohibited in the Disenrollment Discrimination section of the Contract. Violent/threatening situations involve physical acts of violence; physical or verbal threats of violence made against Contracted Providers, staff, or the public at Contractor locations or stalking situations.

2. Contractor must make contact with law enforcement, especially in cases of imminent danger, when appropriate, and refer the Enrollee to mental health Providers when appropriate, before seeking disenrollment of Enrollees who exhibit violent or threatening behavior. MDHHS reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment.

3. When disenrollment is warranted, the effective disenrollment date must be within 60 Days from the date MDHHS received the complete request from the Contractor that contains all information necessary for MDHHS to render a decision. If the Beneficiary exercises their right of Appeal, the effective disenrollment date must be no later than 30 Days following resolution of the Appeal.

4. MDHHS may consider reenrollment of beneficiaries disenrolled in these situations on a case- by-case basis.

5. Contractor is prohibited from requesting disenrollment of an Enrollee for reasons other than those permitted in this Contract.

K. Enrollees Who Move Out of the Contractor's Service Area

1. Contractor must provide all Covered Services to an Enrollee who moved out of the Contractor's Service Area after the effective date of enrollment, until the Enrollee is disenrolled from the Contractor. Contractor may require Enrollees to use Network Providers and provide transportation and/or authorize Out-of-Network providers to provide Medically Necessary services. Contractor may use its

Utilization Management (UM) protocols for hospital admissions and specialty referrals for Enrollees in this situation.

2. Contractor will receive a Capitation Payment for these Enrollees at the approved statewide average rate until disenrollment.

3. When requesting disenrollment, Contractor must submit verifiable information an Enrollee has moved out of the Service Area. MDHHS will expedite prospective disenrollments of Enrollees and process all such disenrollments effective the next available month after confirmation the Enrollee no longer resides in the Contractor's Service Area.

   a. If the Enrollee's street address on the enrollment file is outside of the Contractor's Service Area but the county code does not reflect the new address, the Contractor is responsible for requesting disenrollment within 15 Days of the enrollment effective date.

   b. If the county code on the enrollment file is outside of the Contractor's Service Area, MDHHS will automatically disenroll the Enrollee for the next available month.

L. Long-Term Care

1. Contractor may initiate a disenrollment request if the Enrollee is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than 45 Days. This provision applies equally to Medicaid and Healthy Michigan Plan Enrollees. The facility must be enrolled in the Medicaid program before disenrollment can take place.

2. Contractor must provide MDHHS with medical documentation to support the disenrollment request in a timely manner using the format specified by MDHHS.

3. Contractor must cover all services for Enrollees until the date of disenrollment.

4. MDHHS may require additional information from the Contractor to assess the need for Enrollee disenrollment.

M. Administrative Disenrollments

1. Contractor may initiate disenrollment requests if an Enrollee's circumstances change such that the Enrollee no longer meets the criteria for enrollment with the Contractor as defined by MDHHS. Contractor must request disenrollment within 15 Days of identifying the administrative circumstance.

2. Beneficiaries enrolled in the Healthy Michigan Plan later found to have Medicare eligibility will be retroactively disenrolled by MDHHS. Contractors are not required to submit a disenrollment request.

N. Disenrollment Requests Initiated by the Enrollee

1. Enrollees may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician who does not participate with the Contractor at the time of enrollment. The Enrollee must submit a medical exception request to MDHHS.

2. The Enrollee may request a “disenrollment for cause” orally or in writing from current Contractor at any time during the enrollment period that would allow the Enrollee to enroll with another Contractor. Reasons cited in a request for disenrollment for cause may include:

    a. The Enrollee moves out of the Contractor’s Service Area.

    b. Enrollee’s current Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks.

    c. The Enrollee needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Enrollee's Primary Care Provider or another Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.

    d. Lack of access to Providers or necessary specialty services covered under the Contract. An Enrollee must demonstrate that appropriate care is not available within the Contractor’s Provider Network or through Out-of-Network Providers approved by the Contractor.

    e. Concerns with quality of care.

3. Enrollee may request disenrollment from the Contractor if the open enrollment period was not available due to a temporary loss of Medicaid eligibility. If the Enrollee is mandatorily enrolled and resides in a county with two available MHPs, the Enrollee must choose another MHP in which to enroll; the Enrollee may not return to FFS Medicaid.

4. Enrollee may request disenrollment from the Contractor if the State imposes an intermediate Sanction in which all new enrollments including default enrollment has been suspended from the Contractor for violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

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

O. Medicaid Health Plan Billing Issues and Complaint Resolution

1. When a Complaint or Billing Issue is received by MDHHS, MDHHS will initiate contact with the Contractor.

2. A Complaint is any situation in which a Beneficiary or a Beneficiary's representative expresses a concern about the care or services provided. Types of complaints sent from MDHHS include, but are not limited to, any access to care issue, including vision, dental, mental health, routine healthcare, transportation assistance, prescriptions or other Covered Service.

    a. Within 24-48 hours of receipt of a complaint, Contractor must provide MDHHS with an update on the resolution process or a description of resolution.

3. A Billing Issue is any situation in which a Beneficiary has received a bill for services they believe should have been covered by Medicaid. Billing Issues may include but are not limited to billing statements, collections notices, and/or written descriptions of the issue.

    a. Contractor must provide to MDHHS an update on the resolution process or full resolution of the Billing Issue within 2 weeks of receipt.

V. Access and Availability of Providers and Services

A. Network Requirements

1. Contractor must maintain and monitor a network of Medicaid-enrolled, qualified Providers in sufficient numbers, mix, and geographic locations throughout their respective Service Area, including counties contiguous to Contractor's Service Area, for the provision of all Covered Services.

2. Contractor's Provider Network must be supported by Provider Contracts and sufficient to provide adequate access to all Covered Services for the maximum number of Enrollees specified under this Contract. Contractor must ensure its Provider Network can deliver Covered Services to all Enrollees, including but not limited to Enrollees with limited English proficiency, Enrollees who are deaf or hard of hearing, Enrollees with physical or mental disabilities, Enrollees in CSHCS and Persons with Special Health Care Needs (PSHCN), and must submit documentation to MDHHS to that effect. Adequate access to Covered Services includes compliance with federal regulations at 42 CFR 438 and this Contract.

    a. Contractor must make Covered Services available 24 hours a day, seven days a week, when Medically Necessary.

    b. Contractor must consider anticipated enrollment and expected utilization of services with respect to the specific Medicaid populations (e.g., those populations specified in Section 1.1.V.C.1, below) in the development and administration of its Provider Network.

    c. Contractor must meet the time and distance standards specified in Appendix 15, ensuring PCP, OB/GYN, hospital, pharmacy, mental health, dental and other services identified in Appendix 15 are available from Network Providers within the maximum travel distance and/or time from the Enrollee's home. Provider Network Exceptions, if any, to these time and distance standards will be at the sole discretion of MDHHS. The Provider Network Exception request process is outlined in Section 1.1.V.B.

    d. Contractor must maintain the Network Provider-to-Enrollee ratios specified in Appendix 15, for PCPs for adult and pediatric Enrollees and general dentists, except when a ratio cannot be met because a geographic area does not have sufficient provider capacity. In those instances, Contractor must request a Provider Network Exception as described in Section 1.1.V.B.

e. Contractor must meet and require its Network Providers to meet MDHHS standards for timely access to care and services under this Contract, including standards identified in Appendix 16, and take into account the urgency of the need for services in the delivery of services.

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

g. Contractor must establish mechanisms to ensure Network Providers comply with standards and requirements specified in this Contract. This must include monitoring Network Providers regularly to determine compliance and taking corrective action if there is a failure to comply by any Network Provider.

h. Contractor must notify Enrollee of MDHHS' network adequacy standards, specified in Appendix 15 and Appendix 16, and provide a printed copy of the network adequacy standards to Enrollees upon request. Delivery method of the printed copy will be determined by the Enrollee's request.

i. Contractor must include in its Provider Network at least two FQHCs and at least two RHCs, if available in each Region of its Service Area.

j. To the extent that CenteringPregnancy® programs are available in the Contractor's Service Area, Contractor must include at least one CenteringPregnancy® program in their Provider Network. To the extent that MDHHS approves another evidence-based group prenatal care program or programs in Contractor's Service Areas, Contractor shall include that program or programs in their Provider Network.

k. The availability of Covered Services through telehealth may not be considered in the Contractor's demonstration of network adequacy or its compliance with the network adequacy standards identified in Appendix 15 and Appendix 16.

3. Contractor must submit documentation as specified by MDHHS, but no less frequently than the following:

    a. At the time it enters into a contract with MDHHS

    b. On an annual basis

    c. At any time there has been a significant change in the Contractor's operations that would affect the adequacy of capacity and services, including changes in the Contractor's services, benefits, geographic service area, composition of payments to its provider network, or at the enrollment of a new population.

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

5. Contractor must ensure Enrollees have an ongoing source of primary care appropriate to the Enrollees needs and Covered Services are administered or arranged for by a formally designated PCP.

6. Contractor must provide access to specialists, including specialists in contiguous counties to the Contractor's Service Area, if those specialists are more accessible or appropriate for the Enrollee.

7. Contractor must ensure contracted Providers offer an appropriate range of preventive care, primary care, and specialty services to meet the needs of all Enrollees including Enrollees in CSHCS and PSHCN and submit documentation to MDHHS to that effect.

8. Contractor must maintain a network of pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers necessary to provide care for CSHCS Enrollees. For Enrollees with one or more CSHCS-qualifying diagnoses, including but not limited to those enrolled in the CSHCS program, the Contractor must offer at least two (2) pediatric specialists or pediatric subspecialists qualified to meet the Enrollees' needs. This includes but is not limited to pediatric occupational therapists, pediatric physical therapists, and pediatric speech therapists. If Contractor does not have at least two (2) pediatric specialists or sub-specialists qualified to meet the needs of an Enrollee with one or more CSHCS-eligible diagnosis, then Contractor must reimburse for Covered Services provided by an Out-of-Network Provider. Contractor must inform the Enrollee and the Enrollee's representative of this requirement and assist them with any authorization or referral needed to access care.

9. Contractor must consider the geographic location of Providers and Enrollees, including distance, travel time and available means of transportation ordinarily used by the Medicaid population and whether the Provider Network locations provide access for Enrollees with physical or developmental disabilities.

10. Contractor must participate in MDHHS initiatives (e.g., HHS CLAS), to promote the delivery of services in a culturally responsive manner to all Enrollees, including but not limited to Enrollees with limited proficiency in English, Enrollees who are deaf or hard of hearing, Enrollees with diverse cultural and ethnic backgrounds, and Enrollees with disabilities, and regardless of gender or other factors in accordance with 438.206(c)(2).

11. Contractor must provide for a second opinion from a qualified health care professional within the network or arrange for the Enrollee to obtain one Out-of-Network at no cost to the Enrollee if not available in-network.

12. Contractor must arrange for laboratory services through laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

13. Contractor must ensure Enrollees are provided access to an OB/GYN specialist within the Provider Network to provide for necessary preventive and routine healthcare services. This is in addition to the Enrollee's designated PCP if that Provider is not an OB/GYN.

14. Contractor must require Network Providers to meet MDHHS' standards for timely access to pregnancy care and service under this Contract, including standards in Appendix 16.

15. Contractor must ensure access to non-emergency medical transportation (NEMT) services for Enrollees in accordance with Section 1.1 VI.H.5. of this Contract.

B. Provider Network Exceptions

1. Contractor may request Provider Network Exceptions to the time, distance and Provider-to-Enrollee ratio standards identified in Appendix 15. Approval of any requested Provider Network Exceptions will be at the sole discretion of MDHHS. The Provider Network Exception request must include the following and any additional information specified by MDHHS.

   a. County

   b. Provider type

   c. Current provider counts

   d. Current time, distance and Provider-to-Enrollee ratio figures for the county

   e. An updated Network Access Plan, as described in Section 1.1.V.C , submitted with the Network Exception Request Form, which must include:

      i. A plan for how Contractor will reasonably deliver Covered Services to Enrollees who may be affected by the exception and how Contractor will work to increase access to the applicable provider type in the designated county or counties.

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

2. Provider Network Exceptions, if any, will be at the sole discretion of MDHHS and will consider the number of Providers practicing in the identified type/specialty in the applicable Service Area, the payment rates offered by Contractor to the provider type/specialty subject to the Exception request, and other criteria specified in Appendix 15.

3. If a Provider Network Exception to a time, distance or Provider-to-Enrollee ratio standard is granted by MDHHS, the exception is limited to the identified provider type and county or counties and is granted for a period of up to one year. If the Contractor seeks to extend the network exception needs beyond the first year, Contractor must submit a revised Network Exception request form at the same time as the annual Network Access Plan is submitted for Contract Compliance Review.

C. Network Access Plan

1. Contractor must attest to and demonstrate compliance with network adequacy standards specified in Appendix 15 and Appendix 16 through the Annual Network Access Plan. Contractor must develop, submit, and comply with a Network

Access Plan, which describes its network development and network management activities and results.

2. The Network Access Plan must be updated and submitted to MDHHS on at least an annual basis through the Contract Compliance Review.

3. If Contractor's Provider Network changes such that it no longer meets network adequacy standards, the Contractor must:

    a. Update and submit to MDHHS within ten business days its Network Access Plan to describe the Network non-compliance and how the Contractor is addressing it; and

    b. Immediately update its assessment of capacity, as reported to MDHHS and the Enrollment Services Contractor, to inform new beneficiary enrollment and auto-assignment.

    c. Failure to do (a) and (b), above, may result in MDHHS imposing monetary Sanctions and/or other Sanctions.

4. A revised Network Access Plan must also be submitted when there are changes to the Provider Network as described in Section 1.1.V.B. of this Contract.

5. The Network Access Plan must include any findings of Provider or Contractor noncompliance and any corrective action or other measures taken by the Contractor to bring the Provider and Contractor into compliance.

6. The Network Access Plan must demonstrate that the Contractor:

    a. Offers an appropriate range of preventive, primary care, specialty, mental, dental and NEMT services, in accordance with this Contract, that is adequate for the anticipated number of Enrollees for the Service Area.

    b. Maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area.

    c. Monitors its Network Providers, including through the use of surveys, office visits and/or other mechanism, and acts on changes or gaps in the Provider Network. Changes or gaps in the Provider Network include Exceptions, if any, granted by MDHHS to network adequacy standards, including how the Contractor monitors compliance with Exceptions, addresses network gaps and improves access and availability to Covered Services across its Region(s).

7. Contractor’s Annual Network Access Plan at a minimum must contain the following:

    a. A description of the Contractor’s network, the process and criteria used to select Providers, and the Contractor’s process for reviewing, updating, and submitting its Provider Directory, in accordance with this Contract.

b. Updated geo-access time and distance and Provider-to-Enrollee ratio tables for each county in the Contractor's Service Area, in the format specified by MDHHS. These tables must demonstrate compliance with network adequacy standards in Appendix 15. Contractor must exclude from their tables any Providers that are not accepting new patients, including Providers with some conditions on accepting new patients. Contractor may submit additional information (e.g., time and distance tables that include all Network Providers, even those not accepting new patients).

c. Contractor's process for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the health care needs of Enrollees for all Covered Services, including but not limited to:

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

ii. Methods for assessing the needs of Enrollees and their satisfaction with access to and availability of Covered Services.

iii. Provider ratios, surveys, analyses, and other information to demonstrate Contractor's ability to meet MDHHS' network adequacy standards, including those in Appendix 15 and Appendix 16.

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

v. Access to care in the Contractor's Rural Counties and Counties with Extreme Access Considerations (CEAC) and the Contractor's strategies to maximize access and availability to Covered Services for Enrollees in these areas.

vi. Contractor's procedures and timeframes for making and authorizing referrals and prior authorizations, if applicable, within and outside its Provider Network.

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

i. Contractor's plan for providing continuity of care in the event of new population enrollment, changes in Service Area, covered benefits, contract termination between the Contractor and any of its participating Providers, including major health care groups, Contractor insolvency or other inability to continue

operations.

viii. For any requested or granted Provider Network Exceptions, a description of how the Contractor will address the Network gap and improve access and availability to Covered Services in the specific county and for the specific Provider type/specialty needing an Exception.

ix. For any previously granted Provider Network Exceptions, a report as part of the annual Network Access Plan submission that includes updated information on Enrollee access to affected Covered Services in area(s) where Contractor received an Exception by MDHHS; the report must include actions taken to address network gaps since the Exception was granted and any outstanding barriers and future plans to improve access in the applicable area and for the applicable provider type/specialty.

x. Explanation of how primary office location is determined for PCPs that practice out of several offices.

8. Contractor must reasonably accommodate persons and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The Contractor and its Network Providers must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The Contractor must have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the Contractor by:

   a. Providing flexibility in scheduling to accommodate the needs of Enrollees;

   b. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

      i. Providing large print (in a font size no smaller than 18 point) versions of all written materials to individuals with visual impairments;

      ii. Ensuring that all written materials are available in formats compatible with optical recognition software;

      iii. Reading notices and other written materials to individuals upon request;

      iv. Assisting individuals in filling out forms over the telephone;

v. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

vi. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified American Sign Language interpreters for the Deaf;

vii. Individualized forms of assistance; and

viii. Ensuring safe and appropriate physical access to buildings, services and equipment.

D. Changes in Provider Network

1. Contractor must notify MDHHS within seven Business Days of any changes to the composition of the Contractor's Provider Network that may affect the Contractor's ability to make available all Covered Services in a timely manner.

2. Contractor must have written procedures to address network changes that negatively affect Enrollees' access to care. MDHHS may apply monetary Sanctions and/or other Sanctions to the Contractor if a Provider Network change that negatively affects Enrollees' access to care is not reported timely, or the Contractor is not willing or able to correct the issue in a timely manner.

3. Contractor must submit documentation attesting to network adequacy, including modifications to its Network Access Plan, if:

   a. There are changes in services, benefits, Service Area, or payments.

   b. A new population is enrolled.

4. If Contractor identifies a Provider Network change(s) that affects its ability to meet time, distance or Provider-to-Enrollee ratio standards identified in Appendix 15, Contractor must request in writing a Provider Network Exception within ten Business Days of identifying such a change. Failure to do so may result in MDHHS imposing monetary Sanctions and/or other Sanctions.

5. Contractor must make a good faith effort to give written notice of termination of a Network Provider to each enrollee who received their primary care from, or was seen on a regular basis by, that terminated provider. Notice to the enrollee must be provided by the later of 30 calendar Days prior to the effective date of the termination or 15 calendar Days after receipt or issuance of the termination notice.

E. Timely Access to Care

1. Contractor must ensure Enrollees have access to emergency care 24 hours per day, 7 days per week, in accordance with the network adequacy standards outlined in Appendix 16. All PCPs within the network must have information on

these requirements and reinforce with their Enrollees the appropriate use of the health care delivery system.

2. Contractor must require that physician office visits be available during regular and scheduled office hours.

    a. Contractor must ensure that Enrollees have access to evening and weekend hours of operation in addition to scheduled daytime hours.

    b. Contractor must provide notice to Enrollees of the hours and locations of service for their assigned PCP Network Providers' office hours.

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

    d. Contractor must allow Children in foster care to remain with their established PCP, even if that PCP is not in Contractor's Provider Network.

3. Contractor must make available direct contact with a qualified clinical staff person through a toll-free telephone number at all times, 24 hours per day, 7 days per week.

4. Contractor must monitor Network Providers regularly, including but not limited to the use of surveys or office visits, to assess compliance with the network adequacy standards specified in Appendix 15 and Appendix 16 and report to MDHHS on:

    a. The amount of time between scheduling an appointment and the date of the office visit including routine appointments, urgent appointments, and emergent appointments, including those listed in Appendix 16.

    b. The length of time Enrollees spend waiting in the Provider office.

    c. Any corrective actions.

5. Contractor must meet, and require its Network Providers to meet, MDHHS standards for timely access to care and services, including those specified in Appendix 16, taking into account the urgency of the need for services.

    a. The Contractor shall educate its provider network regarding appointment time requirements.

F. Out-of-Network Providers

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

Network is unable to provide adequate access to covered Medically Necessary services for the identified Enrollee(s).

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

3. Contractor must authorize and reimburse all required Foster Care Well-Child Exams, including any that occurred with an out-of-network provider.

4. Contractor must coordinate with Out-of-Network providers with respect to payment and follow all applicable MDHHS policies to ensure the Enrollee is not liable for costs greater than would be expected for in-network services including a prohibition on balance billing (Section 1.1.XIV.F.6); Medicaid Provider Manual).

5. Contractor must comply with all related Medicaid Policies regarding authorization and reimbursement for Out-of-Network providers.

    a. Contractor must pay Out-of-Network Medicaid providers' claims at established Medicaid fees in effect on the date of service.

    b. If Michigan Medicaid has not established a specific rate for the Covered Service, the Contractor must follow Medicaid Policy to determine the correct payment amount.

G. Primary Care Provider (PCP) Selection

The PCP is responsible for supervising, coordinating, and providing primary care, initiating referrals for specialty care, maintaining continuity of each Enrollee's health care, and maintaining the Enrollee's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services for each assigned Enrollee.

1. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician, nurse practitioners, physician assistants, and other physician specialists when appropriate for an Enrollee's health condition.

    a. Contractor must allow a physician specialist to serve as a PCP when the Enrollee's medical condition warrants management by a physician specialist (e.g., end-stage renal disease, HIV/AIDS, other chronic disease, or disability). Management by a physician specialist will be determined on a case-by-case basis in consultation with the Enrollee.

    b. Contractor must ensure specialists as PCPs can adequately provide all necessary primary care services prior to assigning a specialist as PCP. If the Enrollee disagrees with the Contractor's decision, the Enrollee must be informed of their Grievance and Appeal rights (Section 1.1.XIII.H).

2. Contractor must provide all Enrollees the opportunity to select their PCP at the time of enrollment.

a. If an enrollee does not choose a PCP during the initial enrollment process, Contractor must make a good faith effort to reach all new Enrollees to support their selection of a PCP within 10 Days of enrollment. Contractor must make two subsequent attempts to reach an Enrollee within the first 30 Days if the initial attempt to contact the Enrollee is unsuccessful.

b. When an Enrollee chooses a PCP, Contractor must assign the Enrollee to the PCP of their choice as indicated on the HIPAA 834 daily enrollment file from MDHHS (5970). If Contractor is unable to assign the Enrollee to the PCP due to PCP availability, Contractor must contact the Enrollee to notify and assign a different PCP.

c. Enrollee may choose a clinic as their PCP provided that the Provider files submitted to MDHHS's Enrollment Services Contractor is completed consistent with MDHHS requirements and the clinic has been approved by MDHHS to serve as a PCP.

d. Contractor must allow CSHCS Enrollees to remain with their established PCP, even if that PCP is not in Contractor's Provider Network, at the time of enrollment with Contractor; upon consultation with the family and care team, CSHCS Enrollees may be transitioned to an in-network PCP.

e. Contractor must allow children in foster care to remain with their established PCP, even if that PCP is not in Contractor's Provider Network, at the time of enrollment with Contractor; upon consultation with the family and care team, children in foster care may be transitioned to an in-network PCP.

3. When the Enrollee does not choose a PCP at the time of enrollment, the Contractor must assign a PCP no later than 30 Days after the effective date of enrollment.

a. The Contractor's PCP Assignment methodology must take into consideration:

i. Enrollee claims history, if the Enrollee has Medicaid claims history

ii. Family assignment and/or claims history

iii. Geographic proximity

iv. Availability of handicap accessible public transportation

v. Whether the Enrollee has special health care needs (e.g., Enrollees who are deaf or hard of hearing, Enrollees with physical or mental disabilities, Enrollees in CSHCS, and PSHCN)

vi. Language/cultural preferences

vii. PCP enrollment in Vaccines For Children (VFC) program (for Enrollees under the age of 19)

b. The assigned PCP must be within travel standards in Appendix 15 based on the PCP location compared to the Enrollee's home with the following exceptions:

i. The Enrollee is CSHCS-eligible and a PCP over the travel standards to the Enrollee's home is the most appropriate for the Enrollee.

ii. Contractor has been approved by MDHHS for an exception to the travel time and distance requirements for the Provider type and Region according to criteria in Appendix 15 and is able to document that no other Network Provider is accessible within the travel standards to the Enrollee's home.

c. Enrollees in CSHCS who do not choose a PCP must be assigned either a CSHCS-attested PCP (pursuant to Section 1.1.V.H) or an established PCP as determined by utilization history.

d. Enrollees under the age of 19 who are not enrolled in CSHCS and do not choose a PCP at the time of enrollment must be assigned to a VFC-enrolled provider, to the extent a provider is accessible within time and distance standards in Appendix 15.

4. Contractor must allow Enrollees in CSHCS to choose a non-network PCP if:

a. The Enrollee in CSHCS has an established relationship with the PCP at the time of enrollment with the Contractor.

b. Upon consultation with the family, the selected PCP is the most appropriate for the Enrollee in CSHCS.

5. Contractor must have written policies and procedures describing how Enrollees choose a PCP, are assigned to a PCP, and how they may change their PCP. Contractor must submit these policies and procedures to MDHHS for MDHHS approval at the start of the contract and at least fifteen (15) Days prior to any changes being made.

a. Contractor must provide Enrollees the opportunity to change their PCP regardless of whether the PCP was chosen by the Enrollee or assigned by the Contractor.

b. Contractor must not place restrictions on the number of times an Enrollee can change PCPs with cause.

c. Contractor may establish a policy that restricts the Enrollee's ability to change PCPs without cause; prior to implementing such a policy, Contractor must receive MDHHS approval.

d. Contractor must implement Enrollee PCP assignment within five Business Days of receipt of the Enrollee's PCP selected request.

e. Contractor must report Enrollee's PCP selection, changes, or deletions to MDHHS on the 5284 files within 10 Business Days of change.

f. Contractor must allow Enrollee to change PCP by:

i. Telephone or,

ii. Written notification

g. Contractor may offer an online PCP selection option to Enrollees.

6. At least annually, and when requested by MDHHS, Contractor must review utilization data to identify when Enrollees received primary care from a provider other than their assigned PCP. This review must inform Contractor efforts to improve PCP assignment, including additional outreach to Enrollees, as appropriate, to offer them an opportunity to change PCPs.

7. Contractor must notify all Enrollees assigned to a PCP whose Provider Contract will be terminated and assist them in choosing a new PCP prior to the termination of the Provider Contract.

H. CSHCS PCP Requirements

1. Contractor must assign Enrollees in CSHCS to CSHCS-attested PCP practices that provide family-centered care.

2. Contractor must obtain a written attestation from PCPs willing to serve Enrollees in CSHCS that specifies the PCP/practice meets the following qualifications:

a. Is willing to accept new Enrollees in CSHCS with potentially complex health conditions.

b. Regularly serves children or youth with complex chronic health conditions.

c. Has a mechanism to identify children/youth with chronic health conditions.

d. Provides expanded appointments when children have complex needs and require more time.

e. Has experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, mental health professionals, etc.).

f. Has a designated professional responsible for care coordination for children who see multiple professionals.

g. Provides services appropriate for Health Care Transition, including but not limited to; the use of a transition readiness assessment and adoption of a transition policy that is publicly posted and specifies:

i. the transition time frame

ii. transition approach

iii. legal changes that take place in privacy and consent at age 18

3. Contractor must maintain a roster of Providers who meet the criteria listed above and able to serve Enrollees in CSHCS.

4. Contractor must annually survey network PCPs serving adults to assess availability of these Providers to serve special populations of transition-aged youth and young adults, including Enrollees in CSHCS and those with chronic health conditions.

I. Family Planning Services

1. Contractor must demonstrate that its network includes sufficient family planning Providers to ensure timely access to Covered Services. Family planning providers are providers who provide reproductive health care services to beneficiaries including but not limited to, family planning centers and clinics, OB/GYNs, and PCPs.

2. Contractor must ensure that Enrollees have full freedom of choice of family planning Providers, both in-network and Out-of-Network.

   a. Contractor may encourage the use of public providers in their network.

3. Contractor may encourage family planning Providers to communicate with PCPs once any form of medical treatment is undertaken. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization.

4. Regarding type, duration, or frequency of drugs, supplies and devices for the purpose of family planning, Contractors may not be more restrictive than Medicaid FFS.

5. Contractor must pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service, at established Medicaid FFS rates in effect on the date of service.

6. Contractor must maintain accessibility and confidentiality for family planning services through promptness in scheduling appointments, particularly for minors.

7. Contractor must make certain Medicaid funding is not used for services for the treatment of infertility.

J. Pregnant Enrollees

1. Contractor must allow individuals who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of their choice.

2. Contractor must allow pregnant Enrollees to receive all Medically Necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in-Network Provider.

3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate.

K. Maternity Care

1. Contractor must ensure an individual maternity care Provider is designated for each pregnant Enrollee for the duration of their pregnancy and post-partum care (i.e., 12 months after birth).

    a. Maternity care Providers' scope of practice must include maternity care and meet the Contractor's credentialing requirements.

    b. A clinic or practice may be designated as the maternity care Provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care.

2. Contractor must allow an Enrollee's maternity care Provider to also be the Enrollee's PCP if primary care is within their scope of practice.

L. Child and Adolescent Health Centers

1. Enrollees may choose to obtain Covered Services from a Child and Adolescent Health Centers (CAHCs) Provider without prior authorization from the Contractor. Contractor must pay Medicaid FFS rates in effect on the date of service if the Contractor does not contract with the CAHC.

2. Contractor must contract with any willing CAHC to deliver Covered Services as part of the Contractor's network. If the CAHC is in the Contractor's network, the following conditions apply:

    a. Covered Services must be Medically Necessary and administered by or arranged by a designated PCP.

    b. The CAHC will meet the Contractor's written credentialing and recredentialing policies and procedures for ensuring quality of care and ensuring all Providers rendering services to Enrollees are licensed by the State and operate within their scope of practice as defined for them in Michigan's Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211.

    c. Contractor must reimburse the CAHC according to the provisions of the contractual agreement.

3. In order to promote early intervention of mental health services among the young Medicaid population as an integral component of the delivery system, Contractor must support the MDHHS CAHC mental health services initiative.

    a. Contractor recognizes the need for adequate network access for mild to moderate mental health services for the young Medicaid population.

    b. Contractor must contract with MDHHS designated CAHC organizations who meet the minimum Medicaid Eligibility rate as determined by MDHHS, for increased access to mild-moderate behavior health services for youth 5 through 21 years of age.

    c. Contractor must comply with MDHHS guidance related to payer partner participation in the CAHC initiative including but not limited to:

i. Sharing data and exchanging health information

ii. Submission of CAHC utilization reports as directed by MDHHS.

iii. Making payments according to the CAHC Initiative payment to participating CAHC organizations as determined and instructed by MDHHS.

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

1. Contractor must provide Enrollees with access to and reimburse for services provided through FQHCs and RHCs, including those provided Out-of-Network, with no prior authorization required. Contractor must inform Enrollees of this right in their member handbooks.

2. Contractor must include, in its Provider Network, at least two FQHCs and at least two RHCs, if available in each Region of its Service Area.

3. Contractor must pay FQHCs and RHCs at least as much as the Contractor pays non-FQHC or non-RHC providers for the same service. Contractor must share information and data on payments to FQHCs and RHCs, as specified by MDHHS.

4. FQHCs and RHCs are entitled, pursuant to the Social Security Act and Michigan's State Plan, to Prospective Payment System (PPS) reimbursement. MDHHS will make supplemental payments to FQHCs and RHCs, as needed, to ensure FQHCs and RHCs are paid at the PPS level, in accordance with the Social Security Act and the State Plan.

5. MDHHS reserves the right to revise requirements specified in this section regarding FQHC and RHC payment. This may include, but is not limited to, implementation of an alternative payment model, requirements related to the minimum amount that the Contractor must pay FQHCs and RHCs, and MDHHS' process for making supplemental payments, as needed, to FQHCs and RHCs. Any changes in reimbursement policy will be accounted for in capitation rates. Contractor shall take all necessary actions to comply with any updated requirements from MDHHS.

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

1. Contractor must:

a. Demonstrate that there are sufficient I/T/Us participating in the Provider Network to ensure timely access to services available under the Contract from such Providers for American Indian/Alaska Native Enrollees who are eligible to receive services.

b. Pay I/T/Us, whether in the Provider Network or not, for Covered Services provided to American Indian/Alaska Native Enrollees who are eligible to receive services from such Providers as follows:

i. At a rate negotiated between the Contractor and the I/T/U, or

ii. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would pay for the services to a participating provider which is not an I/T/U; and

iii. Make payment to all I/T/Us in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

c. Permit American Indian/Alaska Native Enrollees to obtain Covered Services from Out- of-Network provider from whom the Enrollee is otherwise eligible to receive such services.

d. Permit an Out-of-Network I/T/U to refer a American Indian/Alaska Native Enrollee to a Network Provider.

2. If timely access to Covered Services cannot be ensured due to few or no I/T/Us, Contractor will be considered to have met the requirement in paragraph (1)(a) of this section if Indian Enrollees are permitted by Contractor to access out-of-State I/T/Us

3. If an Indian Health Facility or I/T/U provider is contracted with the Contractor, American Indian/Alaska Native who are Enrollees must be allowed to choose the I/T/U provider as their PCP as long as the provider has capacity to provide the services. If the I/T/U is not contracted with the Contractor, American Indian/Alaska Native must still be allowed to use the provider without authorization.

4. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903(m) organizations (health plans) and the amount they would receive per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

O. Children's Multidisciplinary Specialty (CMDS) Clinics

1. Contractor must establish and maintain a coordination agreement with each CMDS clinic/facility to ensure coordinated care planning and data sharing, including but not limited to the assessment and treatment plan.

2. Contractor must utilize an electronic data system by which Providers and other entities can send and receive client-level information for the purpose of care management and coordination (Section 1.1.XVI.B).

3. Contractor must cover transportation of Enrollees to CMDS clinics, if requested.

4. Contractor must reimburse for Covered Services provided at CMDS clinics.

5. MDHHS will cover any special facility fees charged by CMDS clinics.

P. Local Health Departments and CSHCS Coordination

1. Contractor must enter into an agreement with all Local Health Departments (LHDs) to coordinate care for CSHCS Enrollees in Contractor's Service Area; the agreement must address the following topics:

    a. Data sharing

    b. Communication on development of Care Coordination Plans

    c. Reporting requirements

    d. Quality assurance coordination

    e. Grievance and Appeal resolution

    f. Dispute resolution and

    g. Health Care Transition for Enrollees initiated prior to age 14 and continuing into young adulthood, including transition readiness assessments and family-centered plans.

2. Contractor must utilize an electronic data system by which Providers and other entities can send and receive client-level information for the purpose of care management and coordination (Section 1.1.XVI.B).

3. Contractor may share Enrollee information with Local Health Departments to facilitate coordination of care without specific agreements.

Q. State Laboratory

1. Contractor must reimburse the State Laboratory (State Lab) for specific tests performed for the Contractor's Enrollees; specific tests for which reimbursement is required are listed in Appendix 11.

    a. Contractor must not require the State Lab to obtain prior authorization or contract with the Contractor for the purposes of providing the laboratory services listed in Appendix 11.

    b. In the absence of a contract or agreement at the time services are performed, the Contractor must make payment to the State Lab at established Medicaid FFS rates in effect on the date of service.

2. The State is responsible for ensuring the State Lab provides all Beneficiary-level data related to the tests listed in Appendix 11 performed by the MDHHS Lab. For all tests performed, the State Lab must provide this data to the Contractor within 90 Days of performing the test.

R. Transition of Care

1. Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and Appendix 14 of this contract to ensure continuity of care for its enrollees.

2. The Contractor's transition of care policy must ensure continued access to services during a transition from FFS to a managed care entity, or transition from

one managed care entity to another when an Enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

3. The Contractor must include instructions to enrollees and potential enrollees on how to access continued services upon transition.

S. Care Coordination

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

2. Contractor must implement procedures to coordinate the care of all Enrollees, including those being served by PIHPs, PAHPs, and the Medicaid FFS program, in accordance with State policy. Contractor must coordinate services furnished to the Enrollee, including but not limited to:

   a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

   b. With the services the Enrollee receives from any other MHP, PIHP or PAHP.

   c. With the services the enrollee receives in FFS Medicaid.

   d. With the services the enrollee receives from community, social support, and other service providers.

3. Contractor must conduct an initial screening of each Enrollee's needs, within 90 Days of the effective date of enrollment of all new Enrollees. Contractor must make a minimum of two (2) subsequent attempts to conduct an initial screening of each Enrollee's needs if the initial attempt to contact the Enrollee is unsuccessful.

   a. The Contractor must conduct additional subsequent screenings of each Enrollee, at a minimum, at annual redetermination and when an enrollee transitions from one care setting to another.

   b. Initial and subsequent screenings pursuant to this paragraph must include screening for Health Related Social Needs, including but not limited to food/nutrition, housing, and non-medical transportation needs using relevant questions from a screening instrument approved by MDHHS. Contractor agrees to comply with screening instrument requirements pursuant to forthcoming MDHHS guidance.

   c. Contractor may utilize Provider-administered screenings to conduct screening for Health Related Social Needs so long as the Contractor can validate that the screening was conducted pursuant to MDHHS guidance using relevant questions from a MDHHS approved screening instrument,

and the Contractor is able to collect screening information from the provider, including all questions answered by Enrollees.

4. Contractor must educate Enrollees about the availability of public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and provide information about how to apply for such benefits, including how to apply through MI Bridges.

5. Contractor must share with the State or other MHPs, PIHPs and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

6. Contractor must ensure that each provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards.

7. Contractor must use and disclose individually identifiable health information, such as medical or dental records and any other health or enrollment information that identifies a particular Enrollee, in accordance with confidentiality requirements in 45 CFR parts 160 and 164.

VI. Covered Services

A. General

1. Contractor must have available and provide, at a minimum, the appropriate Medically Necessary Covered Services. Contractor's standards for determining Medically Necessary Services must not be more restrictive than standards used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes, regulations, the State Plan, Medicaid Provider Manual and other State policy and procedures. The Contractor:

    a. Must provide all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services required under federal law.

    b. Must provide for the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

    c. Must provide for the ability for an Enrollee to achieve age-appropriate growth and development.

    d. Must provide for the ability for an Enrollee to attain, maintain or regain functional capacity.

2. Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

3. Contractor must conform to professionally accepted standards of care and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an Enrollee.

4. Contractor may place appropriate limits on a service: (i) On the basis of criteria applied under the State plan, such as Medical Necessity; or (ii) For the purpose of utilization control, provided that:

    a. Services furnished can reasonably achieve their purpose, as required in this subsection;

    b. Services supporting individuals with ongoing or chronic conditions or who require long- term services and supports are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and

    c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with this Contract.

5. Contractor must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If Medicaid services are added, expanded, eliminated, or otherwise changed, Contractor must implement the changes consistent with State direction and the terms of this Contract.

6. Contractor must ensure all reporting requirements, quality assurance, and compliance activities required by MDHHS of the Contractor apply equally to all Subcontractors used for the provision of Covered Services. Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to the Subcontractor and provides for revoking delegation or imposing monetary Sanctions and/or other Sanctions if the Subcontractor's performance is inadequate. If deficiencies or areas for Improvement are identified, the Contractor and the Subcontractor will take corrective action.

7. Contractor must comply with provisions of MCL 400.109(h) as it relates to pharmaceuticals covered under the medical benefit.

8. Unless otherwise specified in this Contract, Contractor must abide by MDHHS' telehealth coverage and reimbursement policies.

9. Contractor must notify Enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.

B. Services Covered Under this Contract

1. Contractor must provide the full range of Covered Services listed below and any outreach necessary to facilitate Enrollees use of appropriate services. Contractor may choose to provide services over and above those specified. Covered Services provided to Enrollees under this Contract include, but are not limited to, the following:

    a. Ambulance and other emergency medical transportation

    b. Breast pumps; personal use, double-electric

c. Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy

d. Certified nurse midwife services

e. Certified pediatric and family nurse practitioner services

f. Chiropractic services

g. Community Health Worker (CHW)/ Community Health Representative (CHR) services

h. Dental services for adults aged 21 and older

i. Diagnostic laboratory, x-ray, and other imaging services

j. Doula services

k. Durable medical equipment (DME) and supplies including those that may be supplied by a pharmacy.

l. Emergency services

m. End Stage Renal Disease (ESRD) services

n. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)

o. Health education

p. Hearing aids

q. Hearing and speech services

r. Home Health services

s. Hospice services (if requested by the Enrollee)

t. Immunizations

u. Inpatient and outpatient hospital services

v. Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 Days

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

x. Maternal and Infant Health Program (MIHP) services

y. Medically Necessary weight reduction services

z. Mental health services consistent with Appendix 7

aa. Non-emergency medical transportation (NEMT) to medically necessary Covered Services and Medicaid services covered outside of this Contract

bb. Out-of-state services authorized by the Contractor

cc. Parenting and birthing classes

dd. Pharmacy services

ee. Podiatry services

ff. Practitioners' services

gg. Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS.

hh. Prosthetics and orthotics

ii. Restorative or rehabilitative services in a place of service other than a nursing facility

jj. Sexually transmitted infections (STI) treatment

kk. Tobacco cessation treatment including pharmaceutical and behavioral support.

ll. Therapies (speech, language, physical, occupational and therapies to support activities of daily living) excluding therapy services provided to persons with intellectual and/or development disabilities (I/DD) that are billed through PIHPs, Community Mental Health Services Program (CMHSP) providers, or Intermediate School Districts

mm. Transplant services

nn. Vision services

oo. Well-child/EPSDT for persons under age 21

2. Additional Services Covered for Healthy Michigan Plan Enrollees

The Covered Services provided to HMP Enrollees under this Contract include all those listed above and the following services:

a. Habilitative services

3. Preventive Healthcare Services

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

4. Substance Use Disorder in an Inpatient Hospital Setting
    a. Contractor shall provide the coverage of substance use disorder SUD consult services provide for the expert assessment, evaluation, diagnosis, and treatment of individuals during a medically indicated hospital encounter with a co-occurring SUD.

C. Health Promotion and Education

1. Contractor must not charge an Enrollee a fee for participating in health promotion and education programs for Covered Services as delineated in Section 1.1.VI.B.1(all) above.

2. Contractor may charge a nominal fee if the Enrollee elects to participate in programs not primarily related to Covered Services.

D. Pharmacy Services

1. Contractor must provide pharmacy services to Enrollees according to Medicaid Policy and MDHHS-established protocol and in accordance with 42 CFR 438.3(s), Contractor must:

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

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

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

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

2. Contractor must operate a Drug Utilization Review (DUR) program through either a Pharmacy and Therapeutics committee or DUR board for the purpose of meeting coverage standards delineated under Section 1927 of the SSA. The DUR program must comply with the requirements described in section 1927(g) of the Act, 42 CFR part 456, subpart K, as if such requirement applied to the Contractor instead of the State and Section 1004 of the Support for Patients and Communities Act. Contractor's DUR program must include but not be limited to:

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

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

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

d. Include permitted exclusions for Enrollees that are:

i. In hospice or palliative care

ii. Receiving treatment for cancer

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

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

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

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

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

3. Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug, vitamin or supplement that is covered under the Medicaid Pharmaceutical Product List (MPPL).

4. Drug coverages must include over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin, as covered by the Medicaid FFS program.

a. Condoms must be made available to all eligible Enrollees without a prescription; quantity limits for condoms must be no more restrictive than Medicaid FFS.

5. Contractor must provide family planning services in accordance with Section 1.1.V.I. Family Planning Services of this Contract.

6. Contractor must provide tobacco cessation services in accordance with Section 1.1.VI.G Tobacco Cessation of this contract.

7. Contractor must adhere to all MDHHS initiatives related to MCO Common Formulary, rebates, and the delivery of services.

8. Outpatient pharmacy point-of-sale coding must be updated within thirty (30) Days following MDHHS approval of a change to the MCO Common Formulary. Point-of sale coding must be updated within seventy-two (72) hours if an emergency change has been requested by MDHHS.

9. Contractor must provide MDHHS access to the Contractor's published formulary to facilitate MCO Common Formulary compliance monitoring.

10. Contractor must cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program, except in instances where there is an approved patient specific non-formulary prior authorization on file. This applies to both prescription and over-the counter drugs but does not apply to non-drug items such as blood glucose test strips. The MDHHS Medicaid Provider Manual's Directory Appendix identifies the CMS website listing of drug manufacturers participating in the Medicaid Drug Rebate Program (MDRP). Contractor must work with their contracted PBM to determine how they can either use values in their drug reference compendia to identify these drugs or a combination of the CMS list and their drug reference compendia.

11. Contractor must cover products listed on the MDHHS Single Preferred Drug List (SPDL) in accordance with FFS coverage parameters and utilization requirements, including but not limited to:

    a. Prior authorization

    b. Prior authorization criteria

    c. Quantity limits

    d. Age

    e. Gender

12. Contractor must cover as a preferred drug:

    a. All drugs and non-drug items listed as preferred on the MDHHS Single Preferred Drug List found at https://michigan.magellanrx.com/provider/

13. Contractor cannot restrict Single Preferred Drug List products to select pharmacies except when authorized by prior authorization criteria.

14. Contractor must include the corticosteroid deflazacort on the Medicaid Health Plan common formulary.

15. Contractor must submit an attestation of its adherence to the MDHHS' SPDL annually.

16. Contractor must reimburse SPDL preferred brand products at brand reimbursement rates when a dispense as written code of 9 (DAW=9) is submitted.

17. Contractor must reject pharmacy claims with the NCPDP 606 (Brand/Drug/Specific Labeler Code Required) code and include a transaction message informing the pharmacy to bill for the brand and submit DAW=9 whenever a pharmacy submits a claim for a generic SPDL preferred brand product.

18. Contractor must have a SPDL preferred utilization rate of 97%. The SPDL preferred utilization rate will be calculated using as the numerator, the number of paid SPDL preferred product transactions divided by the total number of all paid SPDL product transactions as the denominator.

    a. Contractor must meet the 97% SPDL preferred utilization rate for the period of October 1, 2024 through September 30, 2025.

19. Contractor, including Contractor's Pharmacy Benefit Manager (PBM) or its Subcontractors, is prohibited from negotiating any rebates with drug manufacturers for drugs and non-drug items listed on the MDHHS SPDL and all drugs and non-drug items for which MDHHS has entered into a State supplemental rebate agreement with the manufacturer. If Contractor, its PBM or other subcontractors have an existing rebate agreement with a manufacturer, all covered outpatient drug and non-drug item claims for Medicaid participants for which MDHHS is obtaining State supplemental rebate must be exempt from such rebate agreements. This applies to both prescription, over-the-counter drugs, and non-drug items such as blood- glucose test strips. The MDHHS Medicaid Provider Manual's Directory Appendix identifies the CMS website listing of drug manufacturers participating in the Medicaid Drug Rebate Program (MDRP). Contractor or its Subcontractors may only negotiate with and accept rebates from in relation to drugs that are 1) not listed on the MDHHS SPDL, and 2) not on any supplemental rebate agreement list provided by MDHHS.

20. As directed by MDHHS, Contractor must provide all pharmacy records for prior authorization to facilitate the MDHHS SPDL and MCO Common Formulary compliance monitoring.

    a. Contractor must clearly document prior authorization approval justification for PDL non- preferred and/or products not listed on the SPDL.

21. Contractor must require its pharmacy benefit manager (PBM) or its subcontractors to implement all of the following in accordance with Public Act 279 of 2023.

    a. For Michigan pharmacies with not more than 7 retail outlets, utilizes a pharmacy reimbursement methodology of the lesser of national average drug acquisition cost plus a professional dispensing fee that is at least equal to the applicable professional dispensing fee provided through Section 1620 of Public Act 166 of 2022, wholesale acquisition cost plus a professional dispensing fee provided through Section 1620 of Article 6 of 2020 PA 166, or the usual and customary charge by the pharmacy. The pharmacy benefit manager or the involved pharmacy services administrative organization shall not receive any portion of the additional professional dispensing fee. MDHHS shall identify the pharmacies this

amendment applies to and provide the list of applicable pharmacies to the Contractor.

b. Reimburses for a legally valid claim at a rate not less than the rate in effect at the time the original claim adjudication was submitted at the point of sale.

c. Agrees to move to a transparent “pass-through” pricing model, in which the pharmacy benefit manager discloses the administrative fee as a percentage of the professional dispensing costs to MDHHS.

d. Agrees to not create new pharmacy administration fees and to not increase current fees more than the rate of inflation. This subdivision does not apply to any federal rule or action that creates a new fee.

e. Agrees to not terminate an existing contract with a pharmacy with not more than 7 retail outlets for the sole reason of the additional professional dispensing fee authorized under this amendment.

22. Contractor must not discriminate against nor penalize pharmacies for the use of SPDL preferred brand name products. Contractor failure to adhere to MDHHS SPDL requirements may lead to MDHHS pursuit of contract remedies including but not limited to monetary Sanctions and other Sanctions, such as corrective action.

23. Compliance with the MCO Common Formulary will include but is not limited to:

a. Coverage and Utilization Management tools (e.g., prior authorization, step therapy, quantity limits, and age or gender edits) may be less restrictive, but not more restrictive than the MCO Common Formulary.

b. Contractor must follow the MCO Common Formulary procedures for transitions of care and grandfathering.

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

d. Contractor must provide MDHHS with information regarding the MCO Common Formulary pursuant to Section 1806 of Public Act 207 of 2018.3

e. Mandatory generic coverage is permitted only for products whose drug class(es) are not present on the MDHHS SPDL.

24. Maximum Allowable Cost (MAC) and all other pharmacy pricing standards must be updated at least once every 7 Days.

25. A process for MAC pricing reconsiderations must be developed to ensure compliance with MCL 400.109l. The process must include notification to the requesting pharmacy for MAC pricing reconsideration within 10 Business Days. Notification to the pharmacy must include identification of three National Drug Codes (NDC) if there are 3 or more available, and all available NDCs, if there are fewer than 3, for the drug in question.

26. Contractor is NOT responsible for drugs in the categories listed on the Medicaid Health Plan carve-out list found at https://michigan.magellanrx.com/provider/documents;

    a. Contractor is responsible for covering lab and x-ray services related to the ordering of prescriptions on the carve-out list for Enrollees but may limit access to contracted lab and x-ray Providers.

    b. These medications are reimbursed by the MDHHS pharmacy third party administrator (TPA) through the point-of-sale reimbursement system.

    c. Medications not billed at point-of-sale using the NCPDP format are the responsibility of the Contractor except as noted in the Provider Manual.

27. Contractor must submit pharmacy claims data in accordance with MDHHS Pharmacy 340B policy and claim submission requirements.

28. Contractor's pharmacy Encounter Data must include data elements as required by MDHHS Pharmacy 340B policy and claim submission requirements.

29. Upon MDHHS request, Contractor must promptly collect and share submitted Network Provider claim data and drug purchase details for resolution of drug manufacturer 340B rebate disputes.

30. Contractor must have a unique set of pharmacy billing identifiers for their Medicaid line of business identified on their payer sheets (i.e., a unique combination of National Council of Prescription Drug Program's (NCPDP) Processor ID (previously known as Bank Identification Number (BIN))/American National Standards Institute (ANSI) Issue Identifier Number (IIN) and Processor Control Number (PCN)). The BIN/IIN and PCN are listed on the PBM/processor/plan's Payer Sheets for trading partners to know the proper identifiers for routing transactions. Contractor must require that only this unique set of billing identifiers be used for claim submission and routing purposes for their Medicaid line of business.

31. The Contractor's reimbursement methodology for the Contractor's Pharmacy Benefits Manager (PBM) must be based on the actual amount paid by the PBM to a pharmacy for professional dispensing and ingredient costs. Contractor must prohibit contracted PBMs from engaging in the practice known as "spread pricing," where, in addition to any agreed-upon maintenance fee between the Contractor and the PBM, the PBM charges the Contractor more than the PBM pays the pharmacy for filling a prescription, and the PBM retains the difference.

32. By January 15 of each fiscal year, Contractor must require its pharmacy benefit manager (PBM) to submit all of the following information to MDHHS for the previous fiscal year using the MDHHS provided reporting template:

    a. The total number of prescriptions that were dispensed.

    b. The aggregate wholesale acquisition cost for each drug on its formulary.

    c. The aggregate amount of rebates, discounts, and price concessions that the pharmacy benefit manager received for each drug on its formulary.

The amount of rebates shall include any utilization discounts the pharmacy benefit manager receives from a manufacturer.

d. The aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers.

e. The aggregate amount identified in subdivisions (b) and (c) that were retained by the pharmacy benefit manager and did not pass through to MDHHS or to the Contractor.

f. The aggregate amount of reimbursements the pharmacy benefit manager pays to contracting pharmacies.

g. Any other information as deemed necessary by MDHHS.

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

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

i. All monies related to services provided for the Contractor are passed through to the Contractor, including but not limited to dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, Rebates, Inflationary Payments, and supplemental rebates;

ii. All payment streams, including any financial benefits such as Rebates, discounts, credits, claw backs, fees, grants, charge backs, reimbursements, or other payments that the PBM receives related to services provided for the Contractor are fully disclosed to the Contractor, and provided to MDHHS upon request; and

iii. The PBM is paid an administrative fee which covers their cost of providing the PBM services as described in the PBM contract as well as margin.

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

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

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

i. At least annually, the PBM must hire an independent third party to complete a Service Organization Controls report (SOC-1) audit over the PBM's services and activities. This report must be provided to the Contractor, and information from this audit must be made available to MDHHS upon request.

ii. The PBM must not steer or require any providers or members to use a specific pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between Contractors and PBMs to promote value-based reimbursement and purchasing or enhancing health outcomes are permitted.

iii. The PBM must load member and provider eligibility information into their system within 24 hours of receipt of the eligibility file from the Contractor.

iv. The PBM must report semi-annually to the Contractor their list of specialty drugs by NDC, including a report on any drugs that have moved between specialty and non-specialty designation.

v. The PBM must submit a report containing data from the prior calendar year to the Contractor. The report must be made available to MDHHS upon request and contain the following information:

1. The aggregate amount of all rebates that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor; and

2. The aggregate administrative fees that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor.

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

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

ii. If there is not a provision in the agreement to restrict the PBM from selling pharmacy data, the Contractor must require a secure process to be included and followed. If any Michigan Medicaid Contractor pharmacy data is sold, aggregate total amount

received by the PBM for the Contractor's data must be reported to the Contractor at least semi-annually.

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

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

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

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

34. Contractor must comply with provisions of MCL 400.109(h) as it relates to pharmaceuticals covered under the pharmacy benefit.

E. Emergency Services

1. Contractor must cover Emergency Services and medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USC 1395dd(a)). Enrollees must be screened and stabilized without prior authorization.

2. Contractor must ensure Emergency Services are available 24 hours per day and 7 days per week.

3. Contractor is prohibited from the following:

a. Limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;

b. Refusing to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP of the Enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

c. Denying payment for treatment obtained when an Enrollee had an emergency medical condition, including cases in which the absence of immediate medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

d. Denying payment for treatment obtained when a representative of the Contractor instructs the Enrollee to seek emergency services.

4. Contractor must be responsible for payment of all out-of-network or out-of-area Emergency Services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services.

5. Contractor must cover Emergency Services regardless of whether the emergency department provider or hospital notified the Enrollee's PCP or Contractor of the Enrollee's services in the emergency department. Unless a representative of the Contractor or the Enrollee's PCP instructed the Enrollee to seek Emergency Services, the Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.

6. Contractor must provide emergency transportation for Enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, the emergency transportation provider must submit to Contractor a properly completed and coded claim form for emergency transport, which includes an appropriate diagnosis code as described in Medicaid Policy. Contractor must provide professional services needed to evaluate or stabilize an Emergency Medical Condition found to exist using a prudent layperson standard. Contractor acknowledges that hospitals offering Emergency Services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an Emergency Medical Condition does or does not exist. Contractor further acknowledges that if an Emergency Medical Condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Enrollee.

7. Contractor must ensure that Emergency Services continue until the Enrollee is stabilized and can be safely discharged or transferred.

8. Contractor must cover (consistent with 42 CFR 422.214) post-stabilization care services obtained within or outside the Contractor's network that are pre-approved by a Contractor Provider or other Contractor representative.

9. Contractor must cover post-stabilization care services, regardless of whether the services were provided in the Contractor's network, which are not pre-approved by

    a. Contractor Provider or other Contractor representative but administered to maintain the Enrollee's stabilized condition within 1 hour of a request to the Contractor for pre- approval of further post-stabilization care services.

10. If an Enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services. Such services must be deemed prior authorized under any of the following conditions:

    a. If the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) to a request for authorization made by the emergency department.

11. If the Contractor is not available when the request for post-stabilization services occurs.

    a. If the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria specified below is met.

12. Contractor's financial responsibility for post-stabilization care services not preapproved ends when any of the following conditions are reached:

    a. Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care.

    b. Contractor physician assumes responsibility for the Enrollee's care through transfer.

    c. Contractor representative and the treating physician reach an agreement concerning the Enrollee's care.

    d. The Enrollee is discharged.

F. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (42 USC Sec. 1396D(R)(5), 1396D(A)), is a federal mandate that provides comprehensive diagnostic services, treatment and preventive health care services for children under age 21 who are enrolled in Medicaid. States are required to provide comprehensive services including appropriate preventive, physical health, dental health, mental health, developmental services, and specialty services needed to correct, ameliorate, or maintain health status, based on federal guidelines. EPSDT provides for coverage of all Medically Necessary services included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such services are covered under the State Plan.

1. Contractor must provide EPSDT services as Medically Necessary in accordance with 42 USC Sec. 13®(R)(5), 1396D(A)), 42 CFR part 441, Subpart B, and MSA 16-01 whether or not such services are covered under the State Plan and without regard to established limits. Medically Necessary services for children include all services needed to correct, ameliorate, or maintain health status.

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

3. Contractor must ensure screenings and laboratory services are provided to Enrollees under 21 years of age according to the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule. To access the latest periodicity schedule, see "Recommendations for Preventive Pediatric Health Care" (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf).

4. Contractor must make referrals for diagnostic or treatment services determined Medically Necessary by the Enrollee's health care Provider.

5. Contractor must provide Medically Necessary services. in a timely manner

    a. Children enrolled in Medicaid who request services that do not meet the Contractor's general coverage criteria must receive a secondary review to ensure that the EPSDT provisions have been considered. The Contractor's secondary review process must consider the EPSDT's criteria for Medical Necessity. Denial for services to children cannot be given until this secondary review has been completed.

    b. The Department must approve the Contractor's second review process for EPSDT prior to implementation or when requested.

    c. Contractor must establish a process approved in advance by the Department which allows providers to contact case managers to explore alternative services, therapies, and resources for Enrollees when necessary.

    d. No service provided to a child enrolled in Medicaid under EPSDT can be denied as "non-covered," "out-of-network," and/or "experimental" unless the approved secondary review applying EPSDT criteria has been completed and a determination has been made that the service is not Medically Necessary. Any such denial (non-covered, out-of-network, and/or experimental) shall also state that EPSDT criteria was reviewed and the reason the requested service does not fit the criteria. The Contractor can deny a service specifically noted as a service covered outside of this Contract under Section 1.1.VII. of this Contract. Additionally, the Contractor must inform Enrollees that although a service is covered outside of this Contract and therefore not covered under the Enrollee's Contractor, it may be available through the Department under the Medicaid State Plan or through other delivery systems and provide the appropriate contact information for the Enrollee or their family to inquire with the Department.

6. Contractor must provide outreach to Enrollees due or overdue for well-child/EPSDT visits, including phone, mail, home-visiting or other means of communication acceptable to the Enrollee; the Contractor may meet this requirement by contracting or collaborating with Community-based Organizations and Providers.

7. Contractor must encourage providers, as part of well-child/EPSDT visits, to conduct periodic Health Care Transition readiness/self-care skills assessments and provide anticipatory guidance and health education to assist members with gaining needed self-care skills.

8. Contractor must share at least once annually a MDHHS developed and approved training for licensed Network Providers who see children under the age of 21. Contractor must encourage licensed Network Providers who see children under the age of 21 to complete the training, which will include information on preventive healthcare services for Enrollees less than 21 years of age; coverage and timeliness requirements for Medically Necessary services under the EPSDT mandate; and how to bill for EPSDT covered services to ensure the Provider is receiving reimbursement for Covered Services. The training will be developed by MDHHS for the Contractor to share with Providers and be based on the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule and tailored to the Michigan Medicaid Network Provider community.

G. Tobacco Cessation Treatment

1. Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.

2. Contractor must provide tobacco cessation treatment that includes, at a minimum, the following services:

   a. Intensive tobacco cessation treatment through an MDHHS-approved telephone quit-line.

   b. Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation medication or without

   c. Non-nicotine prescription medications

   d. Prescription inhalers and nasal sprays

   e. The following over-the-counter agents
      i. Patch
      ii. Gum
      iii. Lozenge

   f. Combination therapy – the use of a combination of medications, including but not limited to the following combinations:
      i. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
      ii. Nicotine patch and inhaler
      iii. Nicotine patch and bupropion SR

H. Non-Emergency Medical Transportation

1. Contractor must provide non-emergency medical transportation (NEMT) to and from medically necessary Covered Services and Medicaid services covered outside of this Contract in accordance with Medicaid policy. NEMT includes transportation services as well as reimbursement for travel expenses incurred by or on behalf of the Enrollee.

2. Contractor must ensure NEMT is available 24 hours per day, 7 days a week, 365 days per year.

3. Contractor failure to adhere to NEMT requirements as outlined in this Contract may lead to MDHHS pursuit of contract remedies, including but not limited to monetary Sanctions and other Sanctions, such as corrective action.

4. Contractor must develop and maintain a network of qualified NEMT providers. Contractor must ensure that its network has a sufficient number of vehicles and drivers available to provide safe, appropriate, and reliable transportation services to meet the requirements set forth in this Contract, including but not limited to the network adequacy standards as described in Appendix 15 and Appendix 16.

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

    a. Ongoing services, such as dialysis, chemotherapy, substance use disorder (SUD) services, physical therapy, speech therapy and occupational therapy.

    b. Services for MIHP, or other MDHHS approved evidence-based home-visiting program, enrolled pregnant and infant beneficiaries to access health care and pregnancy-related appointments and for a mother to visit their hospitalized infant. Pregnancy-related appointments include those for oral health services, WIC services, mental or substance use disorder treatment services, and childbirth and parenting education classes.

    c. Regularly scheduled services, for which Contractor may require reasonable advance notice (e.g., 48 – 72 hours) of the need for transportation.

    d. Urgent services, for which the Enrollee requires transportation on the same day as or the day following the request.

    e. Medically necessary, non-emergency ambulance transportation to Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) related services. PIHPs are responsible for transportation to and from the beneficiary's place of residence when the following services are authorized:

        i. Out-of-Home Non-vocational Habilitation Services

        ii. Skill Building Services

        iii. Prevocational Services

        iv. Community Living Support Services

v. Clubhouse Psychosocial Rehabilitation Program

6. Contractor must ensure NEMT providers comply with federal and State transportation safety standards. Additionally, NEMT providers must ensure:

    a. Vehicles used by providers meet the safety needs of the Enrollee, including but not limited to seatbelts and child safety seat requirements, if applicable, and functional heating and air conditioning.

    b. The driver must assist passengers who are unable to fasten their own seat belts.

    c. The number of persons in the vehicle, including the driver, must not exceed the vehicle manufacturer's designed seating capacity.

    d. Upon arrival at the destination, the vehicle must be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination.

    e. Vehicles must always be visible by the driver.

    f. If passenger behavior or other conditions impede the safe operation of the vehicle, the driver must park the vehicle in a safe location out of traffic and notify their dispatcher to request assistance. Enrollee behavior issues are to be reported to the Contractor.

7. Contractor must establish and maintain a toll-free telephone number available 24 hours per day, 7 days per week to assist Enrollees with NEMT requests, including but not limited to coordinating transportation and assisting with reimbursement of travel expenses, as needed.

    a. The telephone number may be the same as the telephone number described in 1.1.XIII.B.6 but must have a dedicated line for NEMT requests.

    b. The telephone number must be included on the Enrollee eligibility card.

8. Contractor must submit to MDHHS at least annually its policies and procedures for the coverage of NEMT, including reimbursement of Enrollee travel expenses.

    a. Contractor must submit equivalent policies and procedures for transportation Subcontractors.

    b. Contractor must provide its policies and procedures and related documentation for monitoring Subcontractors to ensure compliance with all provisions of this Contract, including but not limited to passenger safety, timely access to services, Beneficiary Complaint resolution, mileage reimbursement, and vehicle inspections.

9. Contractor/Subcontractor policies must include but not be limited to provisions for the following:

a. Notifying Enrollees of NEMT benefit, including reimbursement of travel expenses to individuals when it is appropriate for the Enrollee to drive themselves or be driven by a family member, caretaker, friend, neighbor or other individual with a vested interest.

b. Receiving Enrollee NEMT requests, approving NEMT services, and scheduling, assigning, and dispatching NEMT providers, in accordance with the requirements of this Contract.

c. Determining the most appropriate mode of transportation to meet the Enrollee's medical needs and based on the Enrollee's circumstance.

    i. This should include but not be limited to special transport requirements for Enrollees who are medically fragile, Enrollees with physical or mental health needs, Enrollees with an Intellectual and /or Developmental Disability (I/DD), pregnant Enrollees, infants, Enrollees with children, and additional riders needed to accompany Enrollees. It should also consider the need for car seats, whether housing status may affect pick-up and drop-off location(s), and any circumstance where the appointment(s) need to be kept confidential (such as when it is not appropriate for the Enrollee to ask neighbors or family members for transportation).

    ii. Special transport includes but is not limited to medically necessary wheelchair lift-equipped vehicles, Medi-Van vehicles, medically necessary attendants, and other transportation-related needs supported by medical documentation and/or safety protocols.

    iii. Contractor/Subcontractor must ensure the Enrollee or the Enrollee's representative is asked whether there are any special transport needs at the time of scheduling.

d. Notifying Enrollees of transportation arrangements, including notifying Enrollees of the applicable arrangements as soon as the arrangements are made prior to the date of the NEMT service and making a good faith effort to remind Enrollees of the arrangements by telephone 24-hours before the scheduled NEMT service, if applicable.

e. Preventing excessive multi-loading of vehicles such that Enrollees are not unduly burdened or forced to travel for significantly longer periods of time than is necessary or delay the arrival time beyond what is scheduled. The Contractor/Subcontractor and the NEMT providers must ensure Enrollees do not remain in the vehicle for more than 30 minutes longer than the average direct travel time or delay the arrival time beyond what is scheduled.

f. Pick-up and drop-off policies and procedures that ensure:

    i. Pick-up and drop-off times must be based on pre-arranged times as determined by the NEMT provider and the Enrollee or, as applicable, the Enrollee's representative.

ii. Enrollees' must not be kept waiting more than 15 minutes past the scheduled pick-up time.

iii. Drivers must make their arrival for pick-up known to the Enrollee and wait for the Enrollee for at least 15 minutes after the scheduled pick-up time. If the Enrollee is not present fifteen 15 minutes after the scheduled pick-up time, the driver must notify the dispatcher before departing from the pick-up location.

iv. Enrollees must not be required to arrive at their scheduled appointment more than 1 hour before their appointment time.

v. Enrollees must not be dropped off for their appointment before the facility has opened for business, unless requested by the Enrollee or, as applicable, the Enrollee's representative.

vi. Enrollees must be picked up within one (1) hour after notification if there is no prearranged time.

vii. Enrollees must not be picked up from an appointment more than fifteen (15) minutes after the facility closes for business unless requested by the Enrollee or, as applicable, the Enrollee's representative.

g. Contingency plans for unexpected circumstances. The Contractor/Subcontractor or NEMT providers must:

i. Immediately notify the Enrollee or, as applicable, the Enrollee's representative, of any potential delays to the scheduled time for pick-up and/or arrival. The notification must be documented with an indication of whether the Enrollee or their representative was reached or a message was left.

ii. Immediately notify the facility, destination location, and/or the Enrollee's representative at the destination of any delay. The notification must be documented with an indication of whether contact was made or a message was left.

iii. Arrange alternative transportation as needed to ensure the Enrollee receives NEMT services, and notify the Enrollee, the Enrollee's representative(s), as applicable, and the destination location or facility of any changes.

iv. When alternative transportation cannot be immediately arranged, follow up with the Enrollee, the Enrollee's representative as applicable and the facilities to reschedule the services. The follow-up must be documented.

h. Method for reimbursing mileage and other covered NEMT services.

i. Policies related to when an Enrollee must be allowed to have an escort or attendant during NEMT that align with the Medicaid Provider Manual.

j. NEMT complaint resolution and escalation processes.

10. Contractor may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles; prior authorization may not be denied based on distance alone.

11. Contractor must make appropriate accommodations for Enrollees with special transportation needs, including but not limited to Enrollees in CSHCS.

12. Contractor must comply with MDHHS policy regarding NEMT for Enrollees under 18 years of age.

13. MDHHS will monitor transportation services provided by the Contractor. To facilitate oversight, Contractor must:

    a. Collect and maintain documentation of all NEMT services provided, which includes but it not limited to the following information for each trip:

        i. Enrollee ID

        ii. Service reason (i.e., reason the NEMT service was requested)

        iii. Destination

        iv. Scheduled pick-up and drop-off times

        v. Actual pick-up and drop-off times

        vi. Any incidents of delay beyond the times specified in this Contract or missed trip on the part of the Contractor, NEMT provider, or the Enrollee

        vii. Any complaints, including the complaint, complainant name, NEMT service date, complaint reason, complaint resolution, and resolution date.

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

        i. The total number of delayed trips, defined as delayed beyond the times specified in this Contract, and the percent of all trips scheduled that were delayed.

        ii. The total number of missed trips, the percent of all trips scheduled that were missed, and resolution for missed trips.

        iii. Categorized documentation of NEMT-related grievances and appeals. Contractor must monitor and document complaints about NEMT services, including but not limited to those relating to drivers failing to arrive on time or at all for a requested trip and failure to provide transportation that accommodates Enrollee’s needs.

Contractor must document follow-up, including but not limited to whether rescheduling was necessary and any corrective action with the driver or Subcontractor was appropriate.

iv. Documentation log of NEMT-related grievances and appeals must include: complaint reason, complainant name, NEMT service date, transportation provider name, driver name and driver's license number, complaint resolution, and resolution date.

14. Contractor must comply with requirements in the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209, concerning Medicaid coverage of non-emergency medical transportation verification of provider and driving requirements.

Contractor must have a mechanism, which may include attestation, that ensures any agency- based transportation provider or individual driver that furnishes Medicaid-reimbursed non- emergency medical transportation must meet the following minimum requirements:

a. Each provider or individual driver is not excluded from participation in any federal health care program, is not listed on the MDHHS sanctioned provider list, and is not listed on the exclusion list of the Inspector General of the Department of U.S. Health and Human Services; and

b. Each individual driver has a valid driver's license; and

c. Each provider and individual driver must not have been convicted under a federal or state law after August 21, 1996, for a felony criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

d. Each provider and individual driver must disclose and report any felony conviction related to a controlled substance to the Contractor; and

e. Each provider and individual driver must disclose to the Contractor the driving history, including any traffic violations, of each individual driver employed by a provider.

f. Individual drivers who have any of the following convictions in the past two years will be excluded as an NEMT provider:

i. More than two moving violations

ii. Operating While Intoxicated (OWI)

iii. Driving Under the Influence (DUI)

g. Exceptions to the traffic violation exclusion:

i. A family member or foster parent with any of the traffic convictions listed may receive reimbursement for NEMT provided to a member who is unable to consent because of an intellectual or

developmental disability or a legal guardianship, with the written consent of their legally responsible party.

ii. A family member or foster parent with any of the traffic convictions listed may receive reimbursement for NEMT provided to a member who is able to consent to the family member or foster parent providing NEMT after the convictions are disclosed to the participant and the participant signs an acknowledgement form.

h. Applicability:

i. These requirements **are not** applicable to a public transit authority.

ii. These requirements **are not** applicable to the Enrollee.

iii. These requirements **are** applicable to drivers with a vested interest, including an Enrollee's family member, caretaker, friend, neighbor or other individual who has a personal stake or interest in the livelihood of the Enrollee, when they are providing NEMT services to the Enrollee.

iv. These requirements **are** applicable to taxicab drivers.

v. These requirements **are** applicable to transportation network companies, including but not limited to Uber, Lyft and other rideshare companies.

I. Transplant Services

1. Contractor must cover all costs associated with transplant surgery and care; related care may include, but is not limited to, organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs.

2. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, small bowel, and bone marrow including allogenic, autologous, and peripheral stem cell harvesting) must be covered on a patient-specific basis when determined Medically Necessary according to currently accepted standards of care.

3. Contractor must have a process in place to evaluate, document, and act upon such requests.

J. Communicable Disease Services

1. Contractor must allow Enrollees to receive treatment services for communicable diseases from local health departments without prior authorization: including HIV/AIDS, Sexually Transmitted Infections (STI), tuberculosis, and vaccine-preventable communicable diseases.

K. Restorative/Rehabilitative Health Services

1. Contractor must provide restorative/rehabilitative health services or rehabilitative nursing care for Enrollees when Medically Necessary.

a. Enrollees in a nursing facility may receive restorative/rehabilitative care for up to 45 Days (within a rolling 12month period from initial admission).

b. The 45-Day maximum stay does not apply to restorative/rehabilitative health services provided in places of service other than a nursing facility.

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

2. Contractor must coordinate care and supports services provided outside the Contract, such as home help services.

L. Hospice Services

1. Contractor must provide all authorized and medically necessary hospice services in accordance with Medicaid policy and medically accepted standards of care, including “room and board” when provided in a nursing home or hospital.

2. Enrollees who have elected the hospice benefit will not be disenrolled after 45 Days in a nursing home as otherwise permitted for long term care disenrollments.

M. Mental Health Benefit

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

2. Contractor may provide services through contracts with PIHPs, CMHSP providers, or contracts with other appropriate Network Providers.

N. Maternal, Infant and Early Childhood Evidence Based Home Visiting Programs

The Maternal and Infant Health Program (MIHP) is a home-visiting program for Medicaid eligible Enrollees and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP Provider organizations must be certified by MDHHS and adhere to program policies, procedures, and expectations outlined in Medicaid Policy, the MIHP Program Operations Manual and Public Act 291 of 2012.

1. Contractor must refer all eligible Enrollees to an MIHP or other MDHHS approved evidence-based home visiting program. Other MDHHS approved programs are as follows:

a. Nurse Family Partnership

b. Healthy Families America

c. Family Spirit

2. If the Contractor refers an eligible Enrollee to another MDHHS approved evidence-based home visiting program, the Contractor must:

a. Refer the beneficiary within 30 Days of eligibility determination.

b. Track and confirm referrals to completion.

c. Provide MDHHS reports of all beneficiaries referred to other MDHHS approved evidence-based home visiting programs upon request.

3. To administer this benefit to all beneficiaries referred to MIHP Providers, Contractor must establish and maintain agreements with MIHP Provider organizations in the Contractor's Service Area or operate their own MDHHS-certified MIHP.

4. Contractor must educate other contracted providers, pregnant Enrollees and their families about MIHP or other MDHHS approved evidenced-based home visiting programs. Contractor must use related educational materials produced by MDHHS. See also Section 1.1.XIII.C Enrollee Education.

5. Agreements between the Contractor and certified MIHP Provider organizations must be made available to MDHHS upon request and address the following issues:

    a. Medical coordination, including pharmacy and laboratory coordination.

    b. Data and reporting requirements

    c. Quality assurance coordination

    d. Grievance and Appeal resolution

    e. Dispute resolution

    f. Transportation

    g. Enrollee referral to an MIHP Provider organization within 30 Days of MIHP eligibility determination, if Enrollee is not already enrolled in another evidenced based home-visiting program or has not been referred to another evidenced based home-visiting program by the Contractor.

    h. Sufficient number of MIHP Providers to meet Enrollee service and visitation needs within the required response time according to MDHHS MIHP protocols.

    i. Service delivery response times

6. Contractor must refer all MIHP-eligible Enrollees to an MIHP Provider organization utilizing the MDHHS-5650 MHP Communication Tool for MIHP outreach, screening and care coordination within one month of the effective date of MIHP eligibility determination if an Enrollee is not already enrolled in another evidenced based home visiting program or has not been referred to another evidenced based home-visiting program by the Contractor.

    a. MIHP and other MDHHS approved evidence-based home visiting program services are voluntary. Enrollees must be provided an opportunity to select an MIHP Provider organization. If Enrollee does not choose an MIHP Provider organization at the time of MIHP eligibility determination, it is Contractor's responsibility to refer an MIHP Provider organization within one month of the effective date of MIHP eligibility determination.

b. Contractor must provide Enrollees an opportunity to change their MIHP Provider organization among those with which Contractor maintains agreements and to decline MIHP screening and services.

7. Contractor must present to MDHHS evidence of MIHP referral and care coordination, or evidence of participation in an alternative evidence-based home visiting model, or refusal of MIHP services, for all MIHP-eligible Enrollees upon request.

8. Contractor must hold regularly scheduled meetings, not less than quarterly, with each MIHP for the purpose of developing medical coordination processes, including data sharing, workflow to improve resource coordination, and new initiatives to address home-visiting Enrollee needs.

9. Contractor must report annually to MDHHS on the activities undertaken pursuant to this section, including providing a summary and templates of executed agreements, specific examples of collaborative approaches and program successes, and a summary quality improvement initiative will be undertaken and planned to enhance coordination of care management services.

10. If an Enrollee is currently receiving services from an MIHP Provider at the time of enrollment with the Contractor and the Contractor does not have an agreement with that MIHP Provider, the Contractor must pay the MIHP Provider Medicaid FFS rates until case closure.

O. Vaccines and Immunizations

1. Contractor must provide Enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and in accordance with Medicaid Policy. On a quarterly basis, Contractor must identify child and adolescent Enrollees who are not up-to-date on vaccines and immunizations per ACIP guidelines and Medicaid Policy and contact them and their parent/guardian to encourage immunization and identify the reason(s) the Enrollee is not up-to-date. Contractor must assist the Enrollee and their parent/guardian with accessing immunizations. Contractor must document this outreach, including the reason(s) the Enrollee is not up-to-date.

2. Contractor must participate in local and State immunization initiatives/programs

3. Contractor must require contracted Providers to participate with and submit Enrollee data to the Michigan Care Improvement Registry (MCIR). Contractor must offer training and educational materials to Providers to facilitate this process.

4. Contractor must encourage Network Providers who see children under the age of 19 to enroll with the VFC program in order to obtain vaccines and immunizations at no cost and provide them to Enrollees younger than 19 years of age at no cost.

a. Contractor must report to the State annually in the Quality Assessment and Performance Improvement Program (QAPI) report the percentage of Network Providers who see children under the age of 19 and who are enrolled in the VFC program *and* the percentage of well-child visits (using

HEDIS metrics defined by MDHHS) conducted by Network Providers who are enrolled in the VFC program. Contractor must take steps to increase these numbers each year of this Contract and include detailed implementation plans for interventions to improve or sustain improvement in both metrics. Contractor must also evaluate the effectiveness of the interventions based on year-over-year performance. MDHHS may set annual VFC targets for Contractor to meet to ensure increased participation in the program.

5. For Enrollees who receive vaccines and immunizations at local health departments (LHDs) Contractor must reimburse LHDs for all vaccines and immunizations and associated administration fees regardless of whether a contract exists between the Contractor and the LHD.

    a. If a contract does not exist, Contractor must reimburse LHDs for all vaccines and immunizations and associated administration fees at the Medicaid FFS rate in effect on the date of service.

    b. When an Enrollee receives a vaccine or immunization at an LHD participating in the VFC program, the Contractor must reimburse the LHD for the associated administration fee.

6. Contractor must not require prior authorization for any vaccines and immunizations provided to Enrollees at LHDs regardless of Enrollee age or whether the vaccine or immunization was provided as part of the VFC program.

P. Dental Services for Adults

1. Contractor must demonstrate an enhanced network, adequate to provide covered dental services, in accordance with the network standards outlined in Appendix 15. This network must be included in a provider directory available on Contractor's website.

2. Dental Contract with subcontractor must include at a minimum, the requirements outlined in Section 2.3 of this Contract.

3. Contractor must explore and develop incentives to increase participation of dental providers.

4. Contractor must notify its dental subcontractor of Enrollee's eligibility for covered dental services.

5. Contractor must administer covered dental services through the Contractor's managed care structure.

6. Contractor must adhere to the requirements in Section 1.1.XIII.F.1 Member Identification Card. In addition, Contractor must ensure members are aware of how to identify their dental coverage when seeking care from a dental provider.

    a. Members receiving adult dental benefits must be provided a Member Identification card that states the following:

        i. Identification of dental coverage, and/or the dental vendor name.

ii. A customer service phone number to inquire about dental benefits.

b. Contractor may choose to add this information to their existing Member ID card or may issue a separate dental ID card.

c. Member ID cards must be mailed to Enrollees transitioning from Healthy Kids Dental via first class mail within 10 Business Days of the first day of the month after the Enrollee's 21st birthday.

7. Contractor must ensure that dental subcontractor pays providers at a rate that is no less than the Michigan Medicaid FFS rate in effect on the date of service.

8. In order to preserve continuity of care for dental services, Contractor must accept and honor prior authorizations in place for a period up to one year for an Enrollee transitioning from Fee for Service Medicaid.

9. Contractor must adhere to the requirements in Section 1.1.XI.H Medical and Oral Health Coordination and Integration, as well as implement the following:

a. Contractor must present evidence to MDHHS of dental care coordination that details the steps Contractor will take to increase utilization and address barriers to care and issues that contribute to appointment cancellations/no shows.

b. Contractor must support secure bidirectional processes to share data electronically with dental vendor(s) for care coordination purposes, including data related to claims, eligibility, or other records related to the patient experience.

c. Contractor must employ the use of community health workers to assist beneficiaries in navigating the enhanced dental benefit and restructured delivery system.

10. Contractor must provide Enrollees with access to mobile dental services provided by dental facilities listed in the MDHHS Michigan Mobile Dental Facility Permit Directory.

a. Michigan mobile dental facilities are listed at: https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/familyhealth/oralhealth/mobile-dentistry In the event the website is unavailable, anyone seeking the current directory may email the MDHHS-MobileDentistry@michigan.gov mailbox..

b. Contractor must not require prior authorization for mobile dental facilities.

c. Contractor may require mobile dental facilities share Enrollee treatment and treatment data for reimbursement.

d. Contractor must provide mobile dental facilities with Enrollee benefit coverage information upon request.

VII. Coordination for Services Covered Outside this Contract

The Contractor must provide information to the Enrollee regarding the availability of these services and coordinate care as appropriate.

A. General

1. Dental services for all Enrollees under age 21 (except HMP enrollees age 19 and 20)

2. Services provided by a school district and billed through the Intermediate School District

3. Inpatient hospital psychiatric services (see Appendix 7, unless otherwise specified in Section 1.1.VI of this contract)

4. Outpatient partial hospitalization psychiatric care (see Appendix 7)

5. Mental health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance (see Appendix 7)

6. Certain substance use disorder (SUD) services (see Appendix 7), including:

    a. Assessment (per MDHHS policy, MHPs must reimburse SUD services provided in the office setting by a practitioner not enrolled with or associated to a PIHP)

    b. Detoxification (see Appendix 8)

    c. Intensive outpatient counseling and other outpatient services

    d. Methadone treatment and other SUD treatment

7. Services, including but not limited to therapies (speech, language, physical, occupational), provided to persons with intellectual and/or developmental disabilities (I/DD) that are billed through PIHPs, CMHSP providers, or Intermediate School Districts

8. Intermittent or short-term restorative or rehabilitative services (in a nursing facility), after disenrollment

9. Custodial care in a nursing facility

10. Home and Community-Based Waiver Program services

11. Personal care or home help services

B. Services Prohibited or Excluded under Medicaid

1. Contractor is prohibited from using State funds to provide the following services:

    a. Elective cosmetic surgery

    b. Services for treatment of infertility

c. Experimental/investigational drugs, biological agents, procedures devices, or equipment

d. Elective abortions and related services

2. Abortions may be covered if one of the following conditions is met:

a. A physician certifies that the abortion is Medically Necessary to save the life of the mother.

b. The pregnancy is a result of rape or incest.

c. Treatment is for medical complications occurring as a result of an elective abortion.

d. Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy.

3. All appropriate forms relating to abortion must be completed by the designated party and the Contractor must retain these forms for 10 years. The appropriate forms must also be submitted to MDHHS annually as outlined in Appendix 3.

VIII. Mental Health Integration

A. Access to Services for Enrollees with Mental Health Needs

1. Primary Care

a. Contractor must provide training to PCPs on evidence-based mental health service models, such as Screening, Brief Intervention and Referral to Treatment (SBIRT).

b. Contractor must provide information to PCPs on how to refer enrollees to PIHPs and PIHP Network Providers, in accordance with the MDHHS-specified format, process, and timeline.

c. Contractor must ensure access to and reimburse for mental health screening services provided to Enrollees in primary care settings.

d. Contractor must conduct outreach to Enrollees under age 21 who receive services through a PIHP to ensure these Enrollees have access to critical primary care and preventive care services and that such care is coordinated with services received from a PIHP or PIHP Network Provider.

2. Mental Health Care

i. a. Contractor must ensure access to all mental health services covered under this Contract to all Enrollees with mental health needs, in accordance with the Medicaid Mental Health and Substance Use Disorder Authorization and Payment Responsibility Grid available in Appendix 7. MDHHS reserves the right to modify the Medicaid Mental Health and Substance Use Disorder Authorization and Payment Responsibility Grid, including but not

limited to changing coverage responsibility for mental health services so that responsibility will be determined by the level of Enrollees' needs rather than by the setting in which a service is provided.

b. For Enrollees under age 21, Contractor must cover up to 12 sessions of preventive mental health services per Enrollee per calendar year without prior authorization, even if the Enrollee does not have a mental health diagnosis. Contractor must provide access to all medically necessary services, including mental health services, in accordance with federal EPSDT requirements (see 1.1.VI.F). Preventive mental health services include but are not limited to individual, family, and group mental health sessions delivered by a provider practicing in a primary care or mental health care setting and group mental health sessions delivered in community- or school-based settings.

3. Community Health Workers and Peer-Support Specialists

a. For Enrollees who have significant mental health issues and complex physical comorbidities, as defined below, Contractor must offer and arrange for the provision of Community Health Workers (CHW) services in accordance with CHW requirements of this Contract or Peer-Support Specialist Services.

b. Contractor must establish and utilize a reimbursement methodology for outreach, engagement, education, and coordination services provided by plan-employed or subcontracted CHWs or Peer-Support Specialists to promote mental health integration.

B. Collaboration with PIHPs

1. Coordinating Agreements. Contractor must establish and maintain Coordinating Agreements with all PIHPs in their Service Area (Coordinating PIHPs) that address, at a minimum, processes for Enrollee referrals, access to and coordination of care to ensure continuity of care for Enrollees served by both the Contractor and the PIHP, Grievance and Appeal resolution, and other requirements enumerated in this section. (See Appendix 9 for a model Coordinating Agreement.) All Coordinating Agreements must be submitted to and approved by MDHHS.

a. Contractor must separately track and report all Grievances and Appeals for Enrollees jointly served by Contractor and PIHPs.

b. Contractor must establish key contact personnel in each Coordinating PIHP and ensure that each Coordinating PIHP is aware of the Contractor's personnel for ongoing Contractor-PIHP communication and coordination. This must include a designated point of contact at the Contractor to coordinate referrals for mental health services with Coordinating PIHPs and PIHP network providers. The Contractor's designated point of contact must:

i. Have the experience necessary to facilitate referrals for mental health care services both within and outside of the Contractor's Provider Network.

ii. Be available during normal business hours.

iii. Facilitate referrals to and from PIHPs or PIHP Network Providers. This includes but is not limited to: referrals to a PIHP or PIHP Network Provider for an Enrollee who may need specialty services and supports covered by PIHPs; and referrals from a PIHP or PIHP Network Provider for an Enrollee who does not qualify for specialty services and supports covered by PIHPs and/or who seeks mental health care from the Contractor's Provider Network.

iv. Be identified with up-to-date contact information directly to each Coordinating PIHP.

c. Contractor must maintain an electronic bidirectional exchange of information with each Coordinating PIHP (See Section 1.1.XVI.B).

d. Contractor must, in Collaboration with Coordinating PIHPs, review the Coordinating Agreement at least annually to incorporate any necessary modifications or remedies to improve continuity of care, care management, and the provision of health care services.

2. Grievances and Appeals. Contractor must separately track and report all Grievances and Appeals for Enrollees jointly served by Contractor and PIHPs.

3. Joint Community-Based Public Health Initiatives.

a. Contractor must work with each Coordinating PIHP to develop and/or jointly participate in a MDHHS-approved community-based public health initiative or project and report the project results to MDHHS.

b. Contractor and Coordinating PIHPs must meet for this purpose at least quarterly.

c. Contractor and Coordinating PIHPs must include, to the extent possible, key clinical leads at CMHSP providers and other stakeholders in this joint effort.

d. Contractor and Coordinating PIHPs must report projects and ongoing results to MDHHS upon request.

4. Referrals. To facilitate referrals of Enrollees between delivery systems, the, Contractor must:

a. Communicate with the PIHP before and/or at the time of referring an Enrollee to the PIHP.

b. Provide the PIHP with all relevant background information needed to appropriately serve the Enrollee, including but not limited to the reason(s) the Enrollee needs or may need PIHP-covered services, diagnostic information and medical history, any Health-Related Social Need(s), and the Enrollee's contact information. This information sharing must be done

in accordance with MDHHS-specified format, process, and timelines. Contractor must ensure that the referral information is being transmitted to the PIHP's designated point of contact for mental health referral coordination.

c. Have a process to receive and act on referrals from the PIHP and PIHP Network Providers to ensure Enrollee access to needed care.

d. Participate in MDHHS efforts to facilitate information sharing between MHPs and PIHPs.

e. Track all referrals:

i. Made to a PIHP and conduct outreach, as needed, to ensure the Enrollee is able to access PIHP services.

ii. Made from a PIHP or PIHP Network Provider and conduct outreach as needed to ensure the Enrollee is able to access needed services.

f. Electronically document referrals to and from PIHPs and PIHP Network Providers and provide information on these referrals to MDHHS and MDHHS' request.

g. Establish and follow protocols to ensure Enrollees being referred to or from a PIHP or PIHP Network Provider have continuous access to any needed medication and treatment during the period of referral. It is the responsibility of the Contractor to ensure Enrollees do not lose access to necessary medication and treatment during the referral period, which ends when the Enrollee establishes care under a PIHP Network Provider or Contractor Network Provider

h. Share referral information received from a PIHP or PIHP Network Provider with the Enrollee's PCP and any other Providers delivering ongoing treatment or services to the Enrollee, consistent with consent and privacy standards outlined elsewhere in this Contract.

5. Care Management. Contractor must arrange for and provide a robust care management program that meets NCQA and/or URAC accreditation standards and all requirements in this section to all Enrollees with mental health needs who require intensive care management, including but not limited to Enrollees who have significant mental health issues and complex physical comorbidities. Contractor must report to MDHHS annually on the effectiveness of its care management programs in a manner determined by MDHHS.

a. Adult Enrollees (ages 21 and older) who have significant mental health issues and complex physical comorbidities are, at a minimum, Enrollees who meet the following criteria:

i. Have received **one or more** PIHP service in the prior six (6) months;

ii. Have **four or more** emergency department (ED) visits within the prior six (6) months; and

iii. Have diagnoses of **two or more** of any of the following physical health chronic conditions:

i. Asthma
ii. Atrial fibrillation
iii. Cancer (breast, colorectal, lung, prostate or blood cancers)
iv. Chronic kidney disease
v. Chronic Obstructive Pulmonary Disease (COPD)
vi. Congestive heart failure
vii. Diabetes
viii. Hyperlipidemia
ix. Hypertension
x. Ischemic heart disease
xi. Obesity
xii. Osteoporosis
xiii. Rheumatoid arthritis, osteoarthritis, psoriatic arthritis
xiv. Stroke

b. Child and adolescent Enrollees (age 20 and younger) who have significant mental health issues and complex physical comorbidities shall be defined as Enrollees who meet criteria approved by MDHHS.

c. Contractor must work with MDHHS and PIHPs to share data and produce, at intervals designated by MDHHS, a list of Enrollees who have significant mental health issues and complex physical comorbidities, as defined above.

d. Contractor must maintain an electronic bidirectional exchange of information with each Coordinating PIHP (Section 1.1.XVI.B).

e. Contractor must work collaboratively with Coordinating PIHPs to regularly identify and coordinate the provision of services to shared Enrollees who have significant mental health issues and complex physical comorbidities.

f. Contractor must work with PIHPs to provide care management services, including joint care planning that are based on Enrollee needs and goals, as defined by the Enrollee and, for child and adolescent Enrollees, their caregiver (s).

g. Contractor must meaningfully utilize the MDHHS-supported web-based care management system, CareConnect360 (CC360) to document a jointly created care plan and to track contacts, issues, and services regarding shared Enrollees who have significant mental health issues and complex physical comorbidities.

h. Contractor must designate personnel to oversee the appropriate use of CC360. Contractor CC360 personnel must include:

i. One Super Managing Employee (SuME) with the authority to assign Managing Employees. MDHHS approval of the SuME is required.

ii. Managing Employees (not limited in number) with the authority to approve CC360 users, also approved by MDHHS through the Database Security Application (DSA)

i. Contractor and PIHP care managers must hold case reviews at least monthly, during which the care managers and other team members, including CHWs, pharmacists, medical directors, PCPs, and mental health Providers, must discuss shared Enrollees who have significant mental health issues and complex physical comorbidities, and develop shared care management interventions.

6. Shared Metrics. Contractor must work with PIHPs and MDHHS to report on MDHHS-defined shared metrics that seek to measure the quality of care provided to Enrollees jointly served by the Contractor and PIHPs. These shared metrics are included in Appendix 5E.

a. Contractor must work collaboratively with PIHPs, PCPs, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.

b. Contractor must report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.

7. Clinical Integration of Mental Health and Physical Health Services.

a. Contractor must collaborate with PIHPs serving its Enrollees to improve integration of mental health and physical health services through the following activities:

i. Facilitate the placement of primary care clinicians in CMHSPs to enable Enrollees to receive both primary care services and mental health services at the location where they are most comfortable and incorporate principles of shared decision-making.

ii. Facilitate placement of mental health clinicians in primary care settings and provide training on treating patients in a holistic manner, using a single treatment plan that addresses both physical and mental health needs, taking into account unmet needs such as SUD treatment, and helping the individual access community supports.

iii. Develop and implement initiatives to improve communication and collaboration between Contractor’s Provider Network and PIHP Network Providers.

b. To facilitate information sharing and integration at the clinical level, Contractor must ensure its Network PCPs:

i. Establish or update a medical record for any Enrollee assigned to the PCP when mental health information is received from a PIHP or PIHP Network Provider about the Enrollee.

ii. Provide timely responses to information requests from a PIHP or PIHP Network Provider.

iii. Follow the MDHHS-specified format, process, and timelines for making referrals to a PIHP or PIHP Network Provider

8. Emergency Intervention Services. To facilitate coordinated care for Enrollees experiencing a crisis, Contractor must:

a. Establish policies and procedures with Coordinating PIHPs to receive timely notification of any Enrollee utilizing Emergency Intervention Services delivered by a PIHP Network Provider.

b. Within 2 business days of receipt of notification of Emergency Intervention Service utilization, identify and provide to the PIHP and the Emergency Intervention Services provider up-to-date contact information for the following:

i. Any provider of care management services, Peer-Support Specialist and/or Community Health Worker serving the Enrollee;

ii. The Enrollee's PCP; and

iii. Any other Provider(s) delivery ongoing treatment or services to the Enrollee, if applicable.

c. Notify the Providers described above (Section 1.1.VIII.B.8.b.) of the Enrollee's utilization of Emergency Intervention Services.

d. Document the Enrollee's utilization of Emergency Intervention Services and communication with the PIHP and PIHP Network Provider(s) in the Contractor's electronic data system (Section 1.1.XVI.B).

C. Mental Health Parity

1. Contractor must comply with and support MDHHS' compliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438.3(e)(1)(ii), and 42 CFR 438 Subpart K, as applicable to the services covered under this Contract.

IX. Patient-Centered Medical Home Expansion and Coordination

In order to promote Patient-Centered Medical Homes (PCMH) as an integral component of the delivery system, Contractor must support the transformation of primary care practices into Patient Centered Medical Homes and commit to increasing the percentage of Enrollees receiving services from PCMH designated practices through the term of the Contract.

A. PCMH Expansion to Support Population Health

1. Contractor must contract with primary care practices that are recognized as Patient-Centered Medical Homes by National Committee for Quality Assurance

(NCQA) or Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP), or under other PCMH standards approved by MDHHS.

X. Population Health Management

A. Data Aggregation, Analysis and Dissemination

1. General

a. Contractor recognizes that Population Health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age), and the distribution of health conditions, health related behaviors and outcomes including but not limited to physical, dental, mental, and Health Related Social Needs among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age).

b. Contractor must maintain a multi-year plan and execute a process for analyzing data to support Population Health management, including Health Related Social Needs, as outlined in Section 1.1.X.A.2., including:

i. Which factors and/or determinants will be added.

ii. The manner in which data, including Social Determinants of Health (SDOH) data, will be collected and analyzed for each Enrollee.

iii. The manner in which the risk determinations, including SDOH, are validated.

iv. The timeline for implementing the new factors and/or determinants into the data analysis to support Population Health management.

v. The plan for training Contractor staff and embedded care managers on using the data, inclusive of Health Related Social Needs, for Population Health management.

2. Data Analysis to Support Population Health Management

a. Contractor must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by utilization management data, , Health Related Social Needs screening, and eligibility status(i.e., children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS), to address Health Disparities and needs due to SDOH, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:

i. Enrollees who screen positive for Health Related Social Needs including but not limited to housing, food/nutrition and non-medical transportation.

ii. Enrollees demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.

iii. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.

iv. Enrollees with high prevalence Chronic Conditions, such as diabetes, obesity, cardiovascular disease, and oral health disease.

v. Enrollees in need of Complex Care Management, including high risk Enrollees with dual mental health, and medical and oral health diagnoses who are high utilizers of services.

vi. Enrollees with a high-risk pregnancy.

vii. Pregnant Enrollees who screen positive for Health Related Social Needs, including but limited to: housing, food/ nutrition and non-medical transportation.

viii. Children eligible for the Children's Special Health Care Services (CSHCS) program.

ix. Persons with Special Health Care Needs (PSHCN).

x. Other populations with unique needs as identified by MDHHS such as children in foster care or former foster care youth in foster care Transitional Medicaid or members experiencing homelessness.

b. Data Analysis Update Requirements

i. Contractor must systematically stratify newly enrolled Enrollees on a monthly basis.

ii. Contractor must systematically re-stratify the entire Enrollee population, including the stratifications required in Section 1.1.X.A.2 Data Analysis to Support Population Health Management, at intervals designated by MDHHS including if the MHP receives new information about an Enrollee (including upon a significant change in the health status or level of care of the Enrollee; upon the receipt of new information that the plan determines as potentially changing an enrollee's level of risk and need) or at a minimum, annually. Contractor must ensure Enrollees with increasing physical and oral health risks and Health Related Social Needs are identified for Population Health management Services.

iii. MDHHS reserves the right to request the Contractor submit for approval the plan for analyzing data for Population Health management, including incorporation of Health Related Social Needs. Upon request, the Contractor must submit an update to

MDHHS regarding plan implementation, noting compliance with respect to the plan timeline, the plan of correction to realign activities to the timeline, and timeline revisions, if necessary.

3. Data Submission and Data Reporting

a. As requested by MDHHS, the Contractor must participate in initiatives to develop, implement (within an agreed upon timeframe), and continually improve reports for Primary Care Providers that will support activities to improve Population Health management, including but not limited to an actionable list of Enrollees for Primary Care Providers that identify the targeted populations listed in Section 1.1.X.A.2. Data Analysis to Support Population Health Management.

b. MDHHS may, at its discretion, implement a core set of Social Determinants of Health, community-based support service provision, utilization, and physical and oral health outcomes measures that Providers will submit for inclusion in performance measure reports. As requested by MDHHS, the Contractor must participate in initiatives to develop this core measure set including agreement on how the data must be submitted by Providers in order to minimize the administrative burden.

c. Contractor must report to MDHHS and Primary Care Providers, at intervals designated by MDHHS, on the effectiveness of its Population Health management initiatives in a manner determined by MDHHS.

d. Contractor must report on the effectiveness of its Population Health management initiatives including but not limited to:

i. Enrollees who screen positive for Health Related Social Needs including but not limited to housing, food/nutrition and non-medical transportation;

ii. Enrollees participating in additional in person support services such as Community Health Worker, patient navigator, MIHP, or physical and oral health promotion and prevention programs delivered by a Community-based Organization;

iii. Changes in inpatient utilization, emergency department utilization, physician services and outpatient utilization, prescription drug utilization;

iv. Outpatient CMHSP services; and selected health outcomes that are pertinent to the population served.

B. Addressing Health Disparities

1. General

a. Contractor recognizes that Population Health management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity.

i. Contractor must provide Enrollees and families the opportunity to provide feedback to inform health equity initiatives.

b. Contractor must develop protocols for providing Population Health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings:

i. At adult and family shelters for Enrollees who are homeless

ii. The Enrollee's home

iii. The Enrollee's place of employment or school

c. Contractor must implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at https://thinkculturalhealth.hhs.gov/.

2. Community Collaboration Project

a. Contractor must participate with a community-led initiative to improve Population Health in each Region the Contractor serves. Examples of such collaborative initiatives include but are not limited to community health needs assessments (CHNA) and community health improvements plans conducted by hospitals and local public health agencies or other regional health coalitions.

b. Contractors may propose the development of their own Community Collaboration initiative to improve Population Health if such initiatives do not exist in a particular Region.

c. All Community Collaboration projects are subject to MDHHS approval prior to implementation.

3. Services Provided by Community-based Organizations

a. Contractor must enter into one or more agreement(s) with Community-based Organizations (CBOs) in each Region the Contractor serves to support Population Health improvement strategies supported by evidence-based medicine and national best practices in the Contractor's Region, including efforts addressing Social Determinants of Health. Such agreements should include at least one of, but are not limited to, the following activities: referring Enrollees to community-based Social Services to meet health and Health Related Social Needs, providing services to meet Health Related Social Needs, coordinating Social Services between settings and other providers, tracking and reporting on outcomes of referral to address Health Related Social Needs, and assisting members in applying for public benefit programs (SNAP, TANF, WIC, utility and weatherization programs) including through use of MI Bridges, as needed. Contractor agrees to comply with SDOH-focused CBO agreement requirements pursuant to forthcoming MDHHS guidance. Agreements must address:

i. Data sharing

ii. Roles/responsibilities and communication on development of care coordination plans and health related Social Services support

iii. Reporting requirements

iv. Quality assurance and quality improvement coordination

v. Plans for coordinating service delivery with Primary Care Provider

vi. Payment arrangements

b. Contractor must, support the design and implementation of Community Health Worker (CHW) interventions delivered by Community-based Organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to:

i. Conduct home visits to assess barriers to healthy living and accessing health care.

ii. Set up medical, dental and mental health office visits.

iii. Explain the importance of scheduled visits to clients.

iv. Remind clients of scheduled visits multiple times.

v. Accompany clients to office visits, as necessary.

vi. Participate in office visits, as necessary.

vii. Advocate for clients with Providers

viii. Conduct Enrollee assessments to identify and close any gaps in care and address Health Related Social Needs.

ix. Refer Enrollees to community-based Social Services and other resources to address Health Related Social Needs even if they are not Covered Services under this Contract.

x. Coordinate health and Social Services between settings of care, delivery systems, and programs, and with In Lieu of Services (ILOS) providers and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH.

xi. Track outcomes of social care referrals in coordination with service providers, and other community-based social services including but not limited to ILOS providers and other community-based providers.

xii. Assist members in applying for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and using MI Bridges.

xiii. Assist Enrollees if they miss appointments, inquiring why the appointment was missed, and problem-solving to address barriers to care.

xiv. Conduct enhanced outreach (including verifying and seeking out correct contact information for families or contacting families via phone calls, text and emails) to refer Enrollees to the Maternal and Infant Health Program (MIHP) or other home visiting, group prenatal care and connections to postpartum care.

xv. Help boost clients' morale and sense of self-worth.

xvi. Provide clients with training in self-management skills.

xvii. Provide clients with someone they can trust by being reliable, nonjudgmental, consistent, open, and accepting.

xviii. Serve as a key knowledge source for Services and information needed for clients to have healthier, more stable lives.

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

d. MDHHS will give Contractor 1.25 FTE credit toward meeting the contractually required ratio for every 1 FTE Contractor purchases by contracting with a clinic or community-based organization for CHW services for their members. Contractor agrees to comply with CHW-related requirements pursuant to forthcoming MDHHS guidance.

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

f. Contractor must provide that Enrollees have access to an adequate number of CHWs, with a minimum of at least one plan-employed or subcontracted CHW in each of its contracted Prosperity Region Service Areas.

g. Contractor must ensure plan-employed or subcontracted CHWs are trained in all privacy laws and HIPAA provisions, and have successfully completed training in the core competencies available through the CHW Core Consensus Project in order to serve Enrollees in the community.

i. Communication Skills

ii. Interpersonal and Relationship-Building Skills

iii. Service Coordination and Navigation Skills

iv. Capacity Building Skills

v. Advocacy Skills

vi. Education and Facilitation Skills

vii. Individual and Community Assessment Skills

viii. Outreach Skills

ix. Professional Skills and Conduct

x. Evaluation and Research Skills

xi. Knowledge Base

xii. Contractor is expected to ensure additional training related to supporting Enrollees with Health Related Social Needs, including:

i. Screening for Health Related Social Needs.

ii. Conducting Enrollee assessments to identify and close any gaps in care and address Health Related Social Needs when an Enrollee screens positive.

iii. Addressing an Enrollee's health and Health Related Social Needs.

iv. Referring Enrollees to community-based Social Services and other resources to address Health Related Social Needs even if they are not Covered Services under this contract.

v. Ensuring Enrollees receive all necessary services, including, to close any gaps in care and address the Enrollee's Health Related Social Needs.

vi. Coordinating health and Social Services between settings of care, delivery systems, and programs, with external entities outside of Contractor's Provider Network, and with ILOS providers and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH.

vii. Tracking and reporting on outcomes of social care referrals in coordination with community-health workers, service providers, and other community-based social services including but not limited to ILOS providers and other community-based providers.

viii. Assisting members in applying for public benefit programs (e.g., SNAP, TANF, WIC and utility and weatherization programs) and using MI Bridges.

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

i. Contractor is prohibited from utilizing the Community Reinvestment (CR) Obligation to fund CHW services.

C. Health Promotion and Disease Prevention

1. General

a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding; oral health, alcohol and substance use, tobacco use, healthy eating/physical activity, stress, and immunization status.

b. Contractor recognizes that health promotion and disease prevention services must be offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population.

c. Contractor must submit to MDHHS annually a report on its physical and oral health promotion and disease prevention programs, including outreach, referral, and follow- up activities related to Enrollee uptake and participation rates.

2. Health Promotion and Disease Prevention Services

a. Contractor must ensure its Enrollees have access to evidence-based/best practices educational programs, through Contractor programs or referral to local public health/community-based programs, that increase Enrollees' understanding of common risk factors, and evidence-based/best practices wellness programs to engage and track Enrollees' participation in activities that reduce the impact of common risk factors.

b. Such education and wellness programs must be available to Enrollees through multiple sources, which may include but are not limited to websites, social media vehicles, in health care offices and facilities, public schools and through mailings.

c. Contractor must implement educational, public relation and social media initiatives to increase Enrollee and Network Provider awareness of public physical and oral health programs and other community-based resources that are available and designed to reduce the impact of Social Determinants of Health and other common risk factors.

d. Contractor must collaborate with Community-based Organization to facilitate the provision of Enrollee physical and oral health education services to ensure the entire spectrum of psycho-Social Determinants of

Health are addressed (e.g., housing, healthy diet and physical activity, mental health).

3. Contractor must conduct Provider, Beneficiary and Pharmacy outreach to facilitate coordination with the Hep C initiative as outlined in L-Letter 21-21.

   a. Provider outreach must include the following:

      i. Contractor must provide education materials to network providers on the CDC's new universal testing guidelines.

      ii. Contractor must work with providers to incorporate orders for HCV tests in routine primary care for all members.

      iii. Contractor must ensure that CDC HCV testing algorithms are followed (running an HCV virus detection test or PCR for any persons who tests positive for HCV antibody).

      iv. Contractor must promote resources to their network providers listed on Michigan.gov/WeTreatHepC. Contractors are encouraged to develop and share any additional resources that may be useful to network providers.

         i. Contractor must provide targeted outreach and support to network providers in areas where HCV is prevalent (Refer to Viral Hepatitis Annual Surveillance report), as well as to network providers who treat opioid use disorder.

      v. Contractor must work to promote medication adherence with their network providers and pharmacies to ensure that MAVYRET is dispensed in an 8-week supply (or 12-week supply when appropriate). (Refer to *MI Medicaid Maintenance Drug List*).

      vi. Contractor must encourage providers to enroll patients receiving treatment in the MAVYRET Nurse Ambassador program.

   b. Beneficiary outreach must include the following:

      i. Contractor must send all communications as directed by MDHHS. This includes the MDHHS We Treat Hep C Letter Template to beneficiaries 18 years of age and older. In addition, Contractor must send the letter to all new beneficiaries meeting the age requirement. Contractor must also include information about Hepatitis C and the importance of getting tested in beneficiary communications. Communications may include the beneficiary newsletter, member handbook or individual letter.

      ii. Contractor must utilize CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders.

iii. Contractor must develop a list of beneficiaries with an HCV diagnosis and without a record of treatment. The list must include housing information, to assist with this high-risk population, and primary spoken language to provide appropriate outreach materials. Contractor must conduct phone outreach to these beneficiaries. If attempt to reach beneficiary by phone is unsuccessful Contractor must conduct outreach through other means.

iv. Contractor must follow-up with beneficiaries who have a positive HCV test as well as their providers to initiate treatment with MAVYRET.

v. Contractor must work with MDHHS to develop and implement a performance metric and standard ensuring, at a minimum, beneficiaries who have been diagnosed with Hepatitis C are receiving treatment within 12 months or less.

vi. Contractor must conduct outreach to beneficiaries receiving treatment and provide education on medication adherence. Contractors must consult the Daily Carve-Out Utilization File (5165), regarding beneficiaries who are receiving MAVYRET or another DAA.

c. Pharmacy outreach must include the following:

i. Contractor must provide ongoing education to network pharmacies as part of their regular communication requirements including the removal of prior authorization requirement for MAVYRET.

ii. Contractor must work to promote medication adherence with their network providers and pharmacies to ensure that MAVYRET is dispensed in an 8-week supply (or 12-week supply when appropriate). (Refer to *MI Medicaid Maintenance Drug List*).

d. MDHHS will monitor Hepatitis C screening utilization to track an increase in screenings for adults over 18 years of age and pregnant Enrollees during the Contract period.

4. Contractor must conduct Provider and Beneficiary outreach to facilitate increased education and chronic kidney disease (CKD) testing for enrollees with diabetes and hypertension as outlined in L Letter L-23-65.

a. Provider outreach must include the following:

i. Contractor must provide education materials to network providers on testing guidelines.

ii. Contractor must work with providers to incorporate orders for CKD tests in routine primary care for all members with diabetes and hypertension.

iii. Contractor must promote resources to their network providers listed on nkfm.org/areyouthe33 Contractors are encouraged to develop and share any additional resources that may be useful to network providers.

b. Beneficiary outreach must include the following:

i. Contractor must send all communications as directed by MDHHS. Contractor must also include information about the impact of diabetes and hypertension on kidney function and the importance of treatment adherence in beneficiary communications. Communications may include the beneficiary newsletter, member handbook or individual letter.

ii. Contractor must utilize CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders.

5. Healthy Michigan Plan Initial Appointments

a. As established in P.A. 98 of 2023, Contractors must:

i. Facilitate the timely receipt of an Enrollee's Initial Appointment with their PCP.

ii. Educate Network Providers about the Initial Appointment standards.

b.

6. Health Plan Incentive Programs

a. Obligation to Provide Incentive Programs
Health plans are required to offer member incentive programs aimed at fostering participation in health-promoting behaviors. These incentive programs shall include at least one program directed at adults and one program directed at children. The incentive programs must address specific priority areas designated by MDHHS, with a strong emphasis on promoting health equity, supported by evidence-informed strategies.

b. Child-Focused Incentive Programs

The incentive programs directed at children shall encompass at least one of the following priority areas:

i. Immunizations

ii. Asthma care

iii. Well-child visits

iv. Lead screening

c. Adult-Focused Incentive Programs

The incentive programs directed at adults shall encompass at least one of the following priority areas:

i. Immunizations
ii. Prenatal and postpartum care
iii. Dental health
iv. Kidney health
v. Diabetes management
vi. Hypertension management
vii. Cancer screening
viii. Tobacco cessation

d. Submission of Incentive Programs

Health plans shall submit a minimum of two incentive programs for MDHHS review utilizing the provided template. The incentive programs must adhere to the following criteria:

i. Accessibility

The incentive program must be designed to be widely accessible, with minimal barriers to participation. Health plans will be required to provide estimates of the number of qualifying members.

Health plans must ensure that program accessibility includes cultural sensitivity to accommodate the diverse backgrounds and needs of participants. This entails tailoring program components to reflect various cultural perspectives, ensuring that communication and materials are culturally respectful and accessible, and fostering an inclusive environment that recognizes and addresses cultural influences on health behaviors.

ii. Equity

The incentive program must address a documented disparity in health equity. Health plans must outline their strategies for targeted outreach to enhance engagement with underserved populations.

iii. Provider Impact

In cases where the incentive program necessitates provider engagement, health plans must detail their methods for minimizing any adverse impact on providers.

D. Providing Care Management Services and Other Targeted Interventions

1. Care Management Services

a. Contractor must create risk stratification to identify Enrollees by population or sub-population who qualify for intensive care management service, moderate intensity care management services and low intensity care management services.

b. All enrollees identified as being at elevated risk based on risk stratification, must receive an assessment to help inform need and care management service offering.

c. Contractor must offer a robust care management program that meets NCQA and/or URAC accreditation standards to Enrollees who qualify for care management services, and other subpopulations as designated by MDHHS, including but not limited to disabled populations, high-risk pregnancies, and populations with chronic conditions, Enrollees in CSHCS, children in foster care and former foster care youth in Foster Care Transitional Medicaid. When determining additional Enrollees to offer robust care management services, Contractor should consider Health Related Social Needs, including but not limited to: housing, food/nutrition and non-medical transportation.

d. Contractor must develop a care plan for all enrollees receiving care management services.

i. For children in foster care where a PIHP is involved in providing services to the Enrollee, the MHP and PIHP must jointly collaborate on the development and implementation of the care plan.

e. Contractor must, to the extent possible, coordinate with other care managers and the extended care management team.

f. Contractor must help Enrollees obtain Social Services to address Health Related Social Needs, including access to safe and affordable housing, food, fuel assistance and non-medical transportation. To the extent possible, these services (i-vi below) must be offered by or coordinated with the Enrollee's care team. Contractor must:

i. Conduct Enrollee assessments to identify and address Health Related Social Needs when an Enrollee screens positive.

ii. Refer Enrollees to community-based Social Services and other resources to address Health Related Social Needs even if they are not Covered Services under this contract.

iii. Ensure Enrollees receive all necessary services, including ILOS, to close any gaps in care and address the Enrollee's Health Related Social Needs.

iv. Coordinate health and Social Services between settings of care, delivery systems, and programs, with ILOS providers and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

v. Track and report on outcomes of Social Service referrals in coordination with community health workers, service providers, and other community-based social services including but not limited to ILOS providers and other community-based providers.

vi. Assist members in applying for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and using MI Bridges.

g. At a minimum of annually, the Contractor must report to MDHHS the percentage and number of Enrollees that are eligible for and receiving each care management service level provided by the Contractor or providers using an MDHHS-specified reporting template. This report must also include the percentage and number of Enrollees in CSHCS eligible for and receiving each care management service level as a separate item.

i. MDHHS reserves the right to request this information from Contractor more frequently as needed. If requested by MDHHS, Contractor must provide reporting no later than 30 Business Days following request.

h. Contractor must report to MDHHS, at intervals designated by MDHHS, on the effectiveness of its care management initiatives implemented. This report must include information on the effectiveness of the Contractor's care management initiatives implemented for the CSHCS population and Enrollees who screen positive for Health Related Social Needs.

i. CSHCS Enrollee

i. Contractor must offer care management services that meet accreditation standards outlined in Section 1.1.X.D.1.a-f above and support development of a family centered care plan developed in conjunction with the family and care team. If the need for a family-centered plan is determined, the plan must be updated at least annually.

ii. Contractor must collaborate with the family and established primary and specialty care Providers to assure access to the most appropriate Provider for the Enrollee.

iii. Contractor must have separate, specific PA procedures for Enrollees in CSHCS.

1. In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, Contractor must accept prior authorizations in place when the Enrollee in CSHCS is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractor must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization.

2. Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services.

iv. Contractor must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of such equipment.

v. Contractor must ensure services appropriate for Health Care Transition including the adoption of a comprehensive transition policy that specifies:

i. the Contractor's Health Care Transition process (initiated prior to the age of 14 and continuing into young adulthood);

ii. Health Care Transition services available to enrollees/families; and

iii. legal changes that take place in privacy and consent at age 18.

iv. When an individual is eligible for or enrolled in CSHCS and has an ongoing condition(s) that requires a course of treatment or regular care monitoring, Contractor must provide those Enrollees with direct access to specialists through standing referrals for their condition(s) or identified need(s).

vi. Contractor must not implement more restrictive prior authorization policies than what is permitted in Medicaid Fee for Service for pediatric occupational therapy, pediatric physical therapy, and/or pediatric speech therapy for Enrollees in CSHCS and children who are eligible for CSHCS. Contractor must follow guidance outlined in the Medicaid Provider Manual to ensure compliance with these requirements.

j. Persons with Special Health Care Needs (PSHCN)

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

i. Conduct an assessment in order to identify any special conditions that require ongoing care management services for the Enrollee.

ii. Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.

iii. For individuals determined to require care management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the Enrollee.

k. Children Enrolled in Foster Care

i. Contractor must provide care management services to all Enrollees with a Foster Care indicator.

ii. Contractor must initiate contact and actively engage with the foster care worker or the local MDHHS office designee, Health Liaison Officer, and/or the foster care parents to ensure that all children and youth in foster care younger than 21 years of age receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 Days of entering foster care. This visit must be completed regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system.

i. Contractor must adhere to the foster care well child exam protocol provided by the department.

iii. Contractor must report monthly to MDHHS any barriers identified in contacting and/or providing care to Children in Foster Care. The Barrier Report will provide MDHHS Health Liaison Officers (HLOs) with information to assist the Contractor in resolving the barriers reported.

iv. Contractor will coordinate closely with MDHHS and other relevant State-staff through regular meetings to promote system-level coordination for Children in Foster Care. Meetings will occur on a cadence determined by MDHHS and Contractor participation in the meetings is required.

v. Contractor agrees to comply with a care manager ratio of 1:400 for Children in Foster Care and/or former foster care youth in Foster Care Transitional Medicaid.

vi. For children in Foster Care receiving PIHP-covered services, the MHP and PIHP must jointly collaborate on the development and implementation of the care plan.

vii. Care managers working with this population must have an understanding of Michigan’s foster care system, be trained on

trauma-informed care, and have experience working with populations with adverse childhood experiences (ACEs).

viii. Contractor should consider Enrollee's social needs, including but not limited to, housing, food/nutrition, and transportation.

2. Targeted Interventions for Subpopulations Experiencing Health Related Social Needs and Health Disparities:

a. Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who screen positive for Health Related Social Needs. To the extent possible, these services must be offered by or coordinated with the Enrollee's care team.

i. Conduct Enrollee assessments to identify and close any gaps in care and address Health Related Social Needs when an Enrollee screens positive.

ii. Refer Enrollees to community-based Social Services and other resources to address Health Related Social Needs even if they are not Covered Services under this Contract.

iii. Ensure Enrollees receive all necessary services, including ILOS to close any gaps in care and address the Enrollee's Health Related Social Needs.

iv. Coordinate health and Social Services between settings of care, delivery systems, and programs, with external entities outside of Contractor's Provider Network, and with ILOS providers and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

v. Track and report on outcomes of social care referrals in coordination with community-health workers, service providers, and other community-based social services including but not limited to ILOS providers and other community-based providers.

vi. Assist members in applying for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and using MI Bridges. Contractor must be a MI Bridges "Navigation Partner"

b. Contractor must collaborate with its high-volume primary care practices to develop, promote, and implement targeted evidence-based interventions. To the extent that Community Health Innovation Regions (CHIRs) are functioning within the Contractor's Service Area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions.

c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.

d. Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as:

i. Enrollees who screen positive for Health Related Social Needs including but not limited to housing, food/ nutrition and non-medical transportation

ii. Enrollees who had identified Social Care Service needs and received a relevant Social Care Service from a Community-based Organization.

iii. Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a Community-based Organization, and

iv. Changes in Enrollee biometrics and self-reported health status.

E. In Lieu of Services

1. Contractor Provision of In Lieu of Services (ILOS):

a. In accordance with 42 CFR § 438.3(e)(2), the Contractor is strongly encouraged to provide one or more of the MDHHS pre-approved ILOS, which have been determined to be medically appropriate and cost-effective substitutes for Covered Services.

b. Contractors that elect to offer ILOS must adhere to MDHHS requirements described in this contract and Appendix 20. This includes, but is not limited to, adherence to MDHHS service definitions, eligible populations, code sets, and other parameters for each ILOS that the Contractor chooses to provide.

i. Contractor must not extend ILOS to Enrollees beyond those for whom MDHHS has determined the ILOS will be cost-effective and medically appropriate, as outlined in Appendix 20.

ii. Contractor may choose in which Region(s) to offer ILOS. It must, however, make ILOS available for all Enrollees residing within the Region(s) it is electing to offer ILOS. Contractor must report to MDHHS the Region(s) in which it intends to offer ILOS.

c. Contractor must develop and utilize a consistent process for determining and documenting Enrollees for whom ILOS is medically appropriate.

i. The determination must be conducted by the Contractor's licensed clinical staff or Providers in the Provider Network using their professional judgment.

ii. The determination must be documented in the Enrollee's records, such as in an Enrollee's plan of care or medical record.

d. Contractor must not require an Enrollee utilize ILOS. An Enrollee retains the right to receive Covered Services as would apply if ILOS were not an option, in accordance with 42 CFR 438.3(e)(2)(ii), Subpart A.

i. Contractor must ensure medically appropriate Covered Services are available to the Enrollee regardless of whether the Enrollee has been offered ILOS, is currently receiving ILOS, or has received ILOS in the past.

ii. Contractor must not use ILOS to reduce, discourage, or jeopardize an Enrollee's access to Covered Services.

iii. Contractor must update its Member handbook using language developed and approved by MDHHS, consistent with Section 1.1.XIII.F.2.i, to provide information on ILOS and clearly state Enrollee rights and protections related to receiving ILOS.

iv. The grievance, appeal, and state fair hearing provisions in 42 CFR 438.4, Subpart F, applies to Enrollees and ILOS to the same extent and in the same manner as all other Covered Services under the Contract.

e. Contractor's policies and procedures must be submitted to MDHHS for review and approval prior to its implementation. Contractor must submit all documentation in accordance with timeliness requirements outlined in Appendix 20.

2. Approved Nutrition ILOS

a. Contractor may offer Enrollees one or more of the following approved Nutrition ILOS, further described in Appendix 20.

i. Medically Tailored Home Delivered Meal Services. Medically Tailored Home Delivered Meals are defined as a fresh or frozen home delivered meal that is ready to eat and medically tailored for a specific disease or condition. This service includes an initial evaluation with a certified nutrition professional (e.g., Registered Dietitian (RD) or a Registered Dietitian Nutritionist (RDN)) to assess and develop a medically appropriate nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment with a certified nutrition professional at least once every six months.

i. An Enrollee will be eligible to receive Medically Tailored Home Delivered Meal Services if the Enrollee is food insecure and the Enrollee is experiencing at least one or more of the following conditions or circumstances:

1. Has a nutrition-sensitive condition, including diabetes cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal disease, gestational diabetes, other high-risk perinatal conditions or chronic or disabling mental health disorders; or

2. Has been discharged from the hospital or a skilled nursing facility within the last 90 days.

ii. The Contractor shall use or require the use of Healthcare Common Procedure Coding System (HCPCS) Code S5170 with the modifier "V1" to indicate that a Medically Tailored Home Delivered Meal Service was provided.

ii. Healthy Home Delivered Meals. A Healthy Home Delivered Meal is a nutritionally balanced, home delivered meal consisting of a hot, cold, frozen or shelf-stable food aimed at promoting improved nutrition for the service recipient.

i. An Enrollee will be eligible to receive a Healthy Home Delivered Meal if the Enrollee is food insecure and the Enrollee is experiencing at least one or more of the following conditions or circumstances:

1. Has a nutrition-sensitive condition, including diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, hypertension, HIV, cancer, obesity, oral health disease, sickle cell disease, renal disease or a mental health and substance use disorder;

2. Has been discharged from the hospital or a skilled nursing facility within the last 90 days;

3. Has been identified by the Contractor or its designee to be at risk of an avoidable emergency department visit, hospital admission or institutionalization;

4. Is pregnant and currently has, has a history of, or is at risk for at least one of the following: high-risk pregnancy, history of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth, hyperemesis gravidarum and other causes of dehydration, maternal low birth weight of <2500 grams, multiple pregnancy, malnutrition, an acute or chronic respiratory condition, infection, mental health condition, heat stroke or heat exhaustion,

hypothermia, frostbite, or chilblains, abuse or interpersonal violence

5. Is a former foster care youth in Foster Care Transitional Medicaid and at greater risk for an adverse clinical outcome;

6. Is a child with Elevated Blood Lead Levels, at risk of developing chronic or acute conditions due to food insecurity (e.g., failure to thrive, childhood obesity, asthma, depression), or experiencing or previously experienced significant childhood adversity, stress, or trauma that puts the child at a greater risk for an adverse clinical outcome;

7. Is eligible for the Children's Special Health Care Services (CSHCS) program;

8. Is eligible for the Persons with Special Health Care Needs (PSHCN) program; or

9. Is eligible for Medicaid based on an eligibility designation of disability.

ii. The Contractor shall use or require the use of the HCPCS Code S5170 to indicate that a Healthy Home Delivered Meal was provided.

iii. Healthy Food Pack. A Healthy Food Pack is an assortment of medically tailored or nutritionally-appropriate foods provided to an enrollee.

i. An Enrollee will be eligible to receive a Healthy Food Pack if the Enrollee is food insecure and the Enrollee is experiencing at least one or more of the following conditions or circumstances:

1. Has a nutrition-sensitive condition, including diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, hypertension, HIV, cancer, obesity, oral health disease, sickle cell disease, renal disease or a mental health and substance use disorder;

2. Has been discharged from the hospital or a skilled nursing facility within the last 90 days;

3. Has been identified by the Contractor to be at risk of an avoidable emergency department visit, hospital admission or institutionalization;

4. Is pregnant and currently has, has a history of, or is at risk for at least one of the following: high-risk pregnancy, history of previous pregnancy, delivery, or birth complication including gestational diabetes,

preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth, hyperemesis gravidarum and other causes of dehydration, maternal low birth weight of <2500 grams, multiple pregnancy, malnutrition, an acute or chronic respiratory condition, infection, mental health condition, heat stroke or heat exhaustion, hypothermia, frostbite, or chilblains, abuse or interpersonal violence

5. Is a former foster care youth in Foster Care Transitional Medicaid and at greater risk for an adverse clinical outcome;
6. Is a child with Elevated Blood Lead Levels, at risk of developing chronic or acute conditions due to food insecurity (e.g., failure to thrive, childhood obesity, asthma, depression), or experiencing or previously experienced significant childhood adversity, stress, or trauma that puts the child at a greater risk for an adverse clinical outcome;
7. Is eligible for the CSHCS program;
8. Is eligible for the PSHCN program; or
9. Is eligible for Medicaid based on an eligibility designation of disability.

ii. The Contractor shall use or require the use of the HCPCS Code S9977 to indicate that a healthy food pack was provided.

iv. Produce Prescription. A Produce Prescription is a voucher for the Enrollee to purchase any variety of fruits and vegetables or plants/seeds that produce fruits and vegetables from a participating food retailer.

i. An Enrollee will be eligible to receive a Produce Prescription if the Enrollee is food insecure and the Enrollee is experiencing at least one or more of the following conditions or circumstances:

1. Has a nutrition-sensitive condition, including diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, hypertension, HIV, cancer, obesity, oral health disease, sickle cell disease, renal disease or a mental health and substance use disorder;
2. Has been discharged from the hospital or a skilled nursing facility within the last 90 days;
3. Has been identified by the Contractor to be at risk

of an avoidable emergency department visit, hospital admission or institutionalization;

4. Is pregnant and currently has, has a history of, or is at risk for at least one of the following: high-risk pregnancy, history of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth, hyperemesis gravidarum and other causes of dehydration, maternal low birth weight of <2500 grams, multiple pregnancy, malnutrition, an acute or chronic respiratory condition, infection, mental health condition, heat stroke or heat exhaustion, hypothermia, frostbite, or chilblains, abuse or interpersonal violence

5. Is a former foster care youth in Foster Care Transitional Medicaid and at greater risk for an adverse clinical outcome;

6. Is a child with Elevated Blood Lead Levels, at risk of developing chronic or acute conditions due to food insecurity (e.g., failure to thrive, childhood obesity, asthma, depression), or experiencing or previously experienced significant childhood adversity, stress, or trauma that puts the child at a greater risk for an adverse clinical outcome;

7. Is eligible for the CSHCS program;

8. Is eligible for the PSHCN program; or

9. Is eligible for Medicaid based on an eligibility designation of disability.

ii. The Contractor shall use or require the use of the HCPCS Code S9977 with the modifier “V1” to indicate that a Produce Prescription was provided.

b. All four Nutrition ILOS shall be considered substitutes for and are anticipated to reduce the use of the following Covered Services across the eligible enrollee populations:

i. Emergency Medical Transportation

ii. Emergency Services

iii. Home Health Services

iv. Inpatient and Outpatient Hospital Services

v. Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 days

XI. Quality Improvement and Program Development

A. Quality Assessment and Performance Improvement (QAPI) Program

1. Contractor must have an ongoing QAPI program for the services furnished to its Enrollees that meets the requirements of 42 CFR 438.330.

2. Contractor's QAPI must include a) performance improvement projects, b) collection and submission of performance measurement data, c) mechanisms to detect both underutilization and overutilization of services, and d) mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

3. Contractor's Medical Director must be responsible for managing the QAPI program.

4. Contractor must maintain a Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results, and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including but not limited to the Contractor's Medical Director, Quality Improvement Director and other key management staff, as well as health professionals providing care to Enrollees.

5. Contractor's QAPI program must:

   a. Incorporate activities required in Section 1.1.X. Population Health Management.

   ~~b.~~ Identify opportunities to improve the provision of services in support of whole person care, including physical health, mental health, oral health, and Social Determinants of Health.

   c. Incorporate and address findings of Contract compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies.

   d. Establish and address performance improvement goals, objectives, and activities or interventions to improve service delivery and health outcomes for Enrollees. Be made available to MDHHS annually through the Contract compliance review or upon MDHHS request.

6. Contractor must have a written plan for the QAPI program that includes, at a minimum, the following:

   a. Contractor's performance goals and objectives

   b. Lines of authority and accountability

   c. Data responsibilities

   d. Performance improvement activities

   e. Evaluation tools

7. The written plan must describe how the Contractor must:

   a. Analyze the processes and outcomes of care using currently accepted standards from recognized medical authorities. The Contractor may include examples of focused review of individual cases, as appropriate.

   b. Analyze data, including identified Health Related Social Needs and Social Determinants of Health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees.

   c. Develop system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services.

   d. Use measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies, and outcomes of care. Contractor must collect and use data from multiple sources such as HEDIS®, medical and dental records, Encounter Data, claims processing, Grievances, utilization review, and member satisfaction instruments in this activity.

   e. Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement and integrate the work of the Community Collaboration Project into their overall QAPI program.

   f. Compare QAPI program findings with past performance and with established program goals and available external standards.

   g. Measure the performance of Providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by Providers.

   h. At least annually, provide performance feedback to Providers, including detailed discussion of clinical standards and expectations of the Contractor.

   i. Develop and/or adopt, and periodically review, clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to Providers with sufficient explanation and information to enable the Providers to meet the established standards and makes these clinical practice guidelines available to Enrollees upon request.

   j. Ensure that where applicable, Utilization Management, Enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines.

   k. Evaluate access to care for Enrollees according to the established standards and those developed by MDHHS and Contractor's QIC and implement a process for ensuring that Network Providers meet and

maintain the standards. The evaluation must include an analysis of the accessibility of services to Enrollees with disabilities.

l. Perform a member satisfaction survey according to MDHHS specifications and distribute results to Providers, Enrollees, and MDHHS

m. Implement improvement strategies related to program findings and evaluate progress at least annually.

n. Ensure the equitable distribution of physical and oral health care services to their entire population, including members of racial/ethnic minorities, those whose primary language is not English, Rural Area Residents, and those with disabilities.

o. Collect and report data as proscribed by MDHHS including but not limited HEDIS®, CAHPS, and other MDHHS-defined measures that will aid in the evaluation of quality of care of all populations.

p. Defining roles, responsibilities, and procedures for monitoring and continuously improving the following activities:

i. Care Management//case management/disease management

ii. Health promotion and disease prevention

iii. Interventions targeting subpopulations experiencing Health Disparities.

iv. Interventions addressing Health Related Social Needs and the Social Determinants of Health

q. Include narrative detailing the Contractor's lead monitoring activities including goals, objectives, and interventions for improving the health and well-being of children exposed to lead.

B. Annual Effectiveness Review

Contractor must conduct an annual effectiveness review of its QAPI program that includes:

1. Analysis of improvements in the access and quality of physical and oral health care and services for Enrollees as a result of quality assessment and improvement activities and targeted interventions carried out by the Contractor.

2. Consideration of trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.

3. Information on the effectiveness of the Contractor's QAPI program must be provided annually to Network Providers, up request to Enrollees, and annually to MDHHS through the Contract compliance review or upon request.

4. An annual assessment and documentation of the Contractor's QAPI program to include a description of any program completed and all ongoing quality

improvement activities for the applicable year, an evaluation of the overall effectiveness of the program, and an annual work plan.

5. MDHHS may also request other reports or improvement plans addressing specific Contract performance issues identified through site visit reviews, EQRs, focused studies, or other monitoring activities conducted by MDHHS.

C. Annual Performance Improvement Projects

1. Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas including any performance improvement projects required by CMS.

2. Each performance improvement project must be designed to achieve significant improvement, sustained over time, in physical and oral health outcomes and Enrollee satisfaction, and must include the following elements:

   a. Measurement of performance using objective quality indicators.

   b. Implementation of interventions to achieve improvement in the access to and quality of care.

   c. Evaluation of the effectiveness of interventions based on performance measures.

   d. Planning and initiation of activities for increasing or sustaining improvement.

3. Contractor must meet minimum performance objectives. Contractor may be required to participate in statewide performance improvement projects that cover clinical and non- clinical areas that may include but are not limited to examination of disparate access, utilization, or outcomes.

4. MDHHS will collaborate with stakeholders and the Contractor to determine priority areas for statewide performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the population such as care of children, pregnant Enrollees, individuals with chronic conditions, and Persons with Special Health Care Needs, as defined by MDHHS.

5. Contractor must assess performance for the priority areas identified by the collaboration of MDHHS and other stakeholders.

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

D. Performance Monitoring

MDHHS has established annual performance monitoring standards.

1. Contractor must incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QAPI program.

2. MDHHS may use the results of performance assessments as part of the formula for bonus awards and/or automatic enrollment assignments. MDHHS will continually monitor the Contractor's performance on the performance monitoring standards and make changes as appropriate. The performance monitoring standards are included in Appendix 4 and a description of the performance bonus withhold program is included in Appendix 5.

E. External Quality Review

MDHHS will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Contractor. Contractor must participate in annual external quality review which will include but not be limited to the following activities:

1. Address the findings of the external review through its QAPI program.

2. Develop and implement performance improvement goals, objectives, and activities in response to the External Quality Review (EQR) findings as part of the Contractor's written plan for the QAPI.

3. Participate fully and completely with all EQR-related activities as specified by MDHHS and/or federal regulations.

F. Consumer Survey

1. Contractor must conduct an annual survey of their adult Enrollee population using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument.

2. Contractor must directly contract with a National Committee for Quality Assurance (NCQA) certified CAHPS® vendor and submit the data according to the specifications established by NCQA.

3. Contractor must provide NCQA summary and member level data to MDHHS annually.

4. Contractor must provide an electronic or hard copy of the final survey analysis report to MDHHS upon request.

G. Medicaid Health Equity Project

1. Contractor must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

H. Medical and Oral Health Coordination and Integration

1. To effectively address and improve Enrollee overall health status, Contractor recognizes the importance of coordinating and integrating medical health, oral health and Health Related Social Needs to effectively address and improve Enrollee overall health status.

2. Contractor must work with MDHHS to develop initiatives to better coordinate and integrate services covered by the Contractor, dental vendors, and dental Providers serving Contractor's Enrollees.

3. Contractor must collaborate with, PCPs, community partners, dental Providers, dental vendors and MDHHS in the treatment and care of Enrollees.

4. Contractor must promote oral and medical health service collaboration among its Network Providers.

5. Contractor must engage in activities that work to increase awareness about the impact of oral health on Enrollee chronic disease outcomes and improve communication and Collaboration among dental Providers, community partners and medical professionals.

6. Contractor must engage in activities that will educate and build awareness of the benefits of integrated care to its medical Providers and dental Providers as applicable.

7. Contractor must build relationships with community partners that will engage in integrated care and promote good oral health practices.

8. Contractor must encourage its network PCPs to become trained to administer oral health screenings and fluoride varnish Services for patients between zero and three years of age.

9. Contractor must reimburse its network PCPs for Covered Services, including oral health screenings and fluoride varnish application for Enrollees zero to three years of age.

I. Utilization Management (UM)

1. The Utilization Management (UM) activities of the Contractor must be integrated with the Contractor's QAPI program.

2. The major components of Contractor's UM program must encompass, at a minimum, the following:

   a. Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes and comply with all relevant federal and state laws and regulations, including but not limited to the federal laws and regulations on mental health parity (i.e., the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438.3(c)(1)(ii), and 42 CFR 438 Subpart K).

   b. A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

   c. Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

3. Contractor must establish and use a written prior approval policy and procedure for UM purposes. Contractor must conduct an annual review of its UM program and report on utilization review activities, outcomes, and interventions resulting from the review.

a. The Contractor's written prior authorization policy must ensure the review criteria for authorization decisions are applied consistently and require the reviewer consult with the requesting Provider when appropriate.

b. The policy must also require UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

4. For prior authorization decisions related to Enrollees in CSHCS, Contractors are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals, and ancillary providers available and appropriate to render services to Enrollees in CSHCS. Contractor is also encouraged to utilize Office of Medical Affairs Medical Consultants for assistance in determining appropriate durable medical equipment for Enrollees in CSHCS. Contractor must not use UM policies and procedures to avoid providing or reimbursing for Medically Necessary services within the coverages established under this Contract.

5. Contractor's authorization policy must establish timeframes for standard and Expedited Authorization Decisions.

a. These timeframes may not exceed 14 Days from date of receipt for Standard Authorization Decisions and 72 hours from date of receipt for Expedited Authorization Decisions.

b. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an Expedited Authorization Decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

c. These timeframes may be extended up to 14 additional Days if:

i. The Enrollee, or the Provider, requests extension; or

ii. The Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the Enrollee's interest. The Enrollee must be notified in writing of the plan's intent to extend the timeframe.

d. Contractor will begin preparations so that by January 1, 2026, these timeframes may not exceed 7 Days from date of receipt for Standard Authorization Decisions and 72 hours from date of receipt for Expedited Authorization Decisions.

6. Contractor must ensure that compensation to the individuals or Subcontractor that conduct Utilization Management activities is not structured so as to provide incentives for the individual or Subcontractor to deny, limit, or discontinue Medically Necessary services to any Enrollee. If an authorization decision is not made within the specific timeframes, the Contractor must issue an Adverse Action notice.

J. Lead Monitoring

1. Contractor must track and report all cases of minor children who test at or above levels of 3.5 mcg/dl for lead exposure as directed by MDHHS. Contractor must submit the lead report as required in Appendix 3.

2. Contractor must require its providers to follow all clinical, EPSDT, State and Medicaid guidelines and recommendations for childhood lead testing and exposure to lead.

3. Contractor must include its lead monitoring activities and initiatives in its QAPI plan.

K. Performance Measure Data Quality

1. MDHHS will review and validate all performance measure data for completeness and accuracy.

2. Contractor must fully cooperate with all MDHHS efforts to monitor Contractor's compliance with the requirements of performance measure data validation.

3. Contractor must comply with all MDHHS requests related to performance measure data collection, validation and monitoring in a timely manner as directed by MDHHS.

4. Contractor must participate in reviews and assessments conducted by MDHHS or its designee, for the purpose of evaluating Contractor's collection, submission, and maintenance of performance measure data.

5. Contractor must cooperate and comply with any audit arranged for by MDHHS to determine accuracy, truthfulness, and completeness of submitted performance measure data.

   a. Attend and participate in all MDHHS scheduled bi-monthly performance measure quality meetings, including, but not limited to, MDHHS designated meetings on improving immunization rates and Provider participation in VFC.

   b. Submit timely performance measure data in accordance with the MDHHS stated timeframes.

   c. Submit complete and accurate performance measure data in accordance with the MDHHS outlined requirements.

   d. Contractor failure to participate in MDHHS Performance Measure Data Quality activities and reviews in accordance with MDHHS standards may impact scoring for performance bonus and subject Contractor to MDHHS contract remedies including but not limited to monetary Sanctions and other Sanctions, such as corrective action.

XII. Cost-Sharing Requirements

A. Copayments for Medicaid and Healthy Michigan Plan (HMP) Enrollees

1. Contractor may require copayments from Enrollees, consistent with State and federal guidelines and Medicaid Policy upon approval from MDHHS.

2. Contractor's must inform Enrollees of copayment obligations upon enrollment and upon any changes to copayment requirements.

3. Copayment requirements must be listed and explained in the member handbook.

4. Enrollees cannot be denied services based on their inability to pay copayments.

XIII. Enrollee Services

A. Enrollee Rights

1. Contractor must develop and maintain a written policy regarding Enrollee rights and communicate these rights to Enrollees in the member handbook. The Enrollee rights must include, at a minimum, the Enrollee's right to:

    a. Receive information on beneficiary and plan information.

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

    c. Receive Culturally and Linguistically Appropriate Services (CLAS)

    d. Confidentiality

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

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

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

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

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

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

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

B. Informational Materials for Enrollees

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

understand the requirements and benefits of their plan, as required in 42 CFR 438.10.

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

    a. Are available in alternative formats upon request of the Potential Enrollee or Enrollee at no cost.

    b. Include taglines in the prevalent non-English languages in the state, and in a conspicuously visible font size that provide:

        i. Information on the availability of written translation or oral interpretation to understand the information provided;

        ii. Information on how to request auxiliary aids and services;

        iii. The toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit.

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

4. All written materials for potential enrollees and current enrollees must be written in an easily understood language and format, and in a font size no smaller than 12-point.

5. Contractor must use only MDHHS-approved materials and information relating to benefits, coverage, enrollment, Grievances, Appeals, or other administrative and service functions, such as handbooks, newsletters, and other member enrollment materials.

    a. Contractor may reuse a letter template previously approved by MDHHS without obtaining additional approval.

    b. Contractor must submit materials and Medicaid Marketing Approval Worksheet to MDHHS for review and preapproval no less than 15 Business Days prior to use as outlined in the MDHHS Marketing/Branding/Incentive Guidelines for Medicaid Health Plans.

    c. Informational materials must be written at a 6.9 grade reading level or lower.

    d. Formulary drug lists must be made available on the Contractor's website in a machine-readable file. Contractor must make available in electronic

or paper form, the following information about its formulary: (1) which medications are covered (both generic and name brand), and (2) the tier applicable to each medication.

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

6. Contractor must address the need for culturally appropriate interventions for all Enrollee Services. Written materials, available in alternative formats and auxiliary aids and services, must be made available in an appropriate manner that takes into consideration the special needs of the Enrollees or Potential Enrollees with disabilities or limited English proficiency.

7. Contractor must make auxiliary aids and services available upon request of the Potential Enrollee or Enrollee at no cost.

8. Contractor must make interpretation services, including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), available to all Enrollees free of charge.

9. Contractors must notify its Enrollees that:

   a. Oral interpretation is available for any language, and how to access those services;

   b. Written translation is available in prevalent languages, and how to access those services; and

   c. Auxiliary aids and services are available upon request at no cost for Enrollees with disabilities, and how to access those services.

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

11. Contractor must establish and maintain a toll-free 24 hours per day, seven days per week telephone numbers to assist Enrollees with non-emergency medical transportation (NEMT) services.

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

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

   b. The toll-free 24 hours per day, seven days per week NEMT information number stated above.

   c. The Enrollee’s Medicaid ID number.

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

C. Enrollee Education

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

    a. Member handbook.

    b. Contractor bulletins or newsletters sent to Enrollees at least two times per year that provide updates related to Covered Services, access to Providers, updated policies and procedures, and information on the NEMT benefit, including how to access NEMT services, the availability of reimbursement for travel expenses incurred by or on behalf of the Enrollee and when it is appropriate for the Enrollee to drive or be driven by a family member, caretaker, friend, neighbor or individual with a vested interest, and updated policies and procedures.

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

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

        i. How to contact the health plan

        ii. Preventive health strategies

        iii. Health and wellness promotion programs offered by the Contractor

        iv. Updates related to Covered Services and access to Providers and NEMT

        v. Complete Provider directory

        vi. Grievance and appeal information

        vii. MCO common drug formulary

        viii. Member handbook

        ix. Updated policies and procedures, and

        x. Eligibility and enrollment information for public benefit programs, including but not limited to WIC, SNAP and TANF, and utility and weatherization programs and information on how to obtain the Contractor's assistance in applying for public benefit programs and using MI Bridges.

        xi. Maternal Infant Health Program and other MDHHS approved evidence-based home visiting programs

        xii. In Lieu Of Services, if available

    e. Information regarding the appropriate use of health services and prevention of Fraud, Waste, and Abuse.

2. Contractor must make health promotion programs available to the Enrollees.

3. Contractor may provide health education to Enrollees, including health screens, in a Provider office provided the health education meet all of the following criteria:

   a. If a member incentive is offered, it must be delivered in separate private room.

   b. No advertisement of the event may be present or distributed in the Provider office.

   c. Only Contractors' Enrollees may participate.

4. Contractor may provide Medicaid redetermination assistance to current non-MAGI enrollees.

   a. A Contractor that chooses to do this must provide policies and procedures to MDHHS for approval.

   b. Contractor must adhere to the MDHHS Marketing/Branding/Incentive Guidelines for Medicaid Health Plans.

D. Services for Enrollees in CSHCS

1. Contractor must designate specific member services staff to assist Enrollees in CSHCS and provide these member services staff with additional training needed to accommodate the special needs of Enrollees in CSHCS. Enrollees in CSHCS and their family must be able to access the specially trained member services staff directly.

2. Contractor's specially trained staff must reach out to Enrollees in CSHCS at a minimum of every six months in a calendar year via mail, electronic communication (e.g., email, text message), and/or telephone outreach to provide targeted outreach and education to Enrollees in CSHCS, including specific information on navigating prior authorizations and the managed health care system; grievances and appeals; and CSHCS-specific member services available, including but not limited to Health Care Transition prior to age 14 and continuing into young adulthood.

3. Contractor must establish and maintain educational content and outreach information on the Contractor's web site specifically directed to Enrollees in CSHCS with a mechanism for Enrollees in CSHCS and their family to contact specially trained staff to assist them.

4. Contractor must establish and maintain written policies and procedures that provide Enrollees and families the opportunity to provide input on Contractor policies and procedures that influence access to medical services or member services. Contractors are encouraged to develop forums for discussion between the Enrollees in CSHCS and their families and the Contractor.

5. Contractor must ensure that provider directories include up-to-date information about available adult primary, specialty, mental, and reproductive health providers to care for young adults with special health care needs, including those

with developmental disabilities, childhood-onset conditions, mental health conditions and Enrollees in CSHCS.

6. Contractor must ensure that member services staff provide necessary assistance to Enrollees in CSHCS and others with special health care needs, including assisting members who experience difficulties obtaining timely access to adult primary and specialty care, mental health, and reproductive health providers.

E. Services for Children and Youth in Foster Care

1. Contractor must identify and contract with providers that are willing and able to serve as medical home back-up for required well-child exams that are deemed urgent need for children in Foster Care. These providers would be able to provide same-day medical exams for urgent requests.

2. Contractor must authorize and reimburse all required Foster Care Well Child Exams for children in care, as identified by the Foster Care indicator, including any that occurred with an out-of-network provider, in accordance with A.V.D (4) of this contract.

3. Contractor must conduct an internal review of all denied claims for beneficiaries with a current Foster Care indicator and report denial reasons to MDHHS upon request, in accordance with A.XIV.F (4) of this contract.

4. Contractors must provide care management services to all Enrollees with a Foster Care indicator, as provided in Section A.X.D.k.

5. Contractor must designate specific staff to assist children in foster care and provide these member services staff with additional specialized training to accommodate the needs of the foster care population. Children in foster care, their families, and/or their representative, as appropriate, must be able to access the specially trained staff directly. The designated staff must facilitate connections between Contractor's care managers, Health Liaison Officers, foster care workers and the local MDHHS office designee, PIHP staff and CMHSP providers (as applicable), and/or the child's Family Team. Contractor shall:

   a. Be responsible for maintaining up-to-date records and contact information for the assigned Contractor care manager, Health Liaison Officer, and foster care workers and the local MDHHS office designee, PIHP staff and CMHSP providers (as applicable), and/or the child's Family Team.

   b. Facilitate connections between any parties involved in the child in foster care's care.

6. Contractor must provide targeted outreach and education to children preparing to transition out of foster care, including but not limited to Health Care Transition prior to age 14 and continuing into young adulthood before transitioning or "aging out" of foster care. Contractor must ensure care managers for children in foster care are trained on the Youth in Transition program, including available funding under the program and navigating access to such funding. Care managers must participate in all transition planning meetings for enrollees and follow guidance outlined in the Children's Foster Care Manual for transition planning. Additional contractor support must include, but is not limited to:

a. Working with the Family Team to assess the child in foster care's home and community support needs to remain in the community and maintain stability through the transition into adulthood and out of foster care including:

i. Identifying and assessing risks included but not limited to health related social needs, continuity of care and medication compliance;

ii. Assessing needs and providing recommendation for access for specialized supports including but not limited to positive mental health supports, medication support, Durable Medical Equipment, communication devices or vehicle or home adaptations; and

iii. Determining and identifying the array of services needed and Network Providers of these services.

b. Reviewing the child in foster care's health status and other appropriate factors to determine if the child meets the general eligibility criteria for entering a waiver program, such as but not limited to the Section 1915(c) MI Choice Waiver, Section 1915(c) MI Habilitation Supports Waiver, Section 1915(c) MI Health Link HCBS Waiver, and Section 1915(b) Healthy Kids Dental Waiver, and if the child appears to meet the general eligibility criteria, help initiate the waiver application processes and if necessary, support the child in foster care in applying to be on the waiver waiting list(s); and

c. Working with the child in foster care's Family Team to educate the child and family about options for services and supports available after eligibility terminates.

F. Member Materials

1. Member Identification Card

a. Contractor must mail member ID cards to Enrollees via first class mail within 10 Business Days of being notified of the Enrollee's enrollment.

b. All other printed information, not including the member ID card, but including member handbook and information regarding accessing services may be delivered separately from the ID card.

i. Member materials stated above must be delivered to Enrollee within 10 Business Days of being notified of the member's enrollment.

ii. Contractor may distribute new member packets to each household instead of to each individual member in the household, provided that the mailing includes individual health plan membership cards for each member enrolled in the household when ID cards and other member information are mailed together.

c. Notification must be provided to affected Enrollees when programs or service sites change at least 10 Business Days prior to changes taking effect.

d. For enrollees covered in the adult dental benefit, member identification cards must include reference to dental coverage benefit as outlined in VI. P. Dental Services for Adults.

2. Member Handbook

Contractor must use the state developed Model Enrollee Handbook. Contractor must make any necessary revisions and distribute to members within timeframe specified by MDHHS. Contractor must provide each Enrollee with a Member Handbook, which serves as a summary of benefits and coverage, within a reasonable time after receiving notice of the beneficiary's enrollment. The Member Handbook must include information that enables the Enrollee to understand how to effectively use the managed care program.

a. Contractor's member handbook must be written at no higher than a 6.9 grade reading level and be available in Alternative Formats for Enrollees with special needs.

b. Member handbooks must be available in a Prevalent Language when more than 5% of the Contractor's Enrollees speak a Prevalent Language, as defined by MDHHS policy.

c. Contractor must provide a mechanism for Enrollees who are blind or deaf and hard of hearing or who speak a Prevalent Language as described above to obtain member materials and a mechanism for Enrollees to obtain assistance with interpretation.

d. Contractor must agree to make modifications in the handbook language to comply with the specifications of this Contract.

e. Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least once a year and updated when necessary.

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

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

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

iii. Posts the information on the Contractor's website and advises the Enrollee in paper or electronic form that the information is available on the internet and includes the exact address to access the information. The Contractor must also provide that Enrollees

with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

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

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

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

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

i. At a minimum, the member handbook must include the following information as specified in 42 CFR 438.10(g)(2) and any other information required by MDHHS:

   i. Table of contents.

   ii. Advance Directives, including, at a minimum: (1) information about the Contractor's Advance Directives policy, (2) information regarding the State's Advance Directives provisions and (3) directions on how to file a Complaint with the State concerning non-compliance with the Advance Directive requirements. Any changes in the State law must be updated in this written information no later than 90 Days following the effective date of the change.

   iii. Availability and process for accessing Covered Services that are not the responsibility of the Contractor but are available to its Enrollees.

   iv. Description of all available Contract services, including any In Lieu of Services offered, consistent with Section 1.1.X.E.1.d.iii..

   v. Description of copayment requirements.

   vi. Designation of specialists as a PCP.

   vii. Enrollees' rights and responsibilities which must include all Enrollee rights specified in 42 CFR 438.100 (a)(1), 42 CFR 438.100(c), and 42 CFR 438 102(a).

   viii. The Enrollee rights information must include a statement that conveys that Contractor staff and affiliated Providers will comply with all requirements concerning Enrollee rights.

ix. Enrollees' right to direct access to network OB/GYN specialists and pediatric Providers for Covered Services necessary to provide routine and preventive health care services without a referral.

x. Enrollees' right to receive FQHC and RHC services.

xi. Enrollees' right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.

xii. Enrollees' right to request information on the structure and operation of the Contractor.

xiii. Enrollees' rights and protections related to receiving ILOS, if ILOS is offered by the Contractor, consistent with Section 1.1.X.E.1.d.iii.

xiv. Explanation of any service limitations or exclusions from coverage.

xv. Explanation of counseling or referral services that the Contractor elects not to provide, reimburse for, or provide coverage of, because of an objection on moral or religious grounds. The explanation must include information on how the Enrollee may access these services.

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

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

xviii. How to access hospice services.

xix. How to choose and change PCPs.

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

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

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

xxiii. How to obtain emergency transportation.

xxiv. How to obtain NEMT to and from medically necessary, Covered Services and services covered outside of this Contract. This should include information on how to obtain reimbursement for travel expenses incurred by or on behalf of the Enrollee, when appropriate.

xxv. How to file a Complaint concerning the provision of NEMT services.

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

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

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

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

xxx. How to access community-based supports and services in Enrollees' Service Area.

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

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

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

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

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

xxxvi. Well-child care, immunizations, and follow-up services for Enrollees under age 21 (EPSDT). For enrolled individuals under age 21 entitled to the EPSDT benefit, information on how to access EPSDT services.

xxxvii. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. The extent to which, and how, after hours and emergency coverage is provided, including: (1) what constitutes an emergency medical condition and Emergency Services, (2) the fact that prior authorization is not

required for Emergency Services, and (3) the fact that the Enrollee has a right to use any hospital or other setting for emergency care. Enrollees must be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations.

xxxviii. What to do when family size changes.

xxxix. Eligibility and enrollment information for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and information about using MI Bridges.

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

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

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

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

xliv. Information on how to report suspected Fraud or Abuse.

xlv. Information from Transition of Care Policy on how to access continued services upon transition to health plan.

xlvi. Contractor's Health Care Transition policy.

j. Contractor must give Enrollee notice 30 Days prior to intended effective date of any significant changes outlined in Section 1.1.XIII.F.2.i., Member Handbook.

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

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

3. General Information Requirements

a. If the Contractor chooses to provide required information electronically to Enrollees, the following criteria must be met:

i. It must be in a format that is readily accessible.

ii. The information must be placed in a location on the Contractor's website that is prominent and readily accessible.

iii. The information must be provided in an electronic form which can be electronically retained and printed.

iv. The information is consistent with content and language requirements.

v. The Contractor must notify the Enrollee that the information is available in paper form without charge upon request.

vi. The Contractor must provide, upon request, information in paper form within 5 business days.

4. Medicaid Certificate of Coverage

a. Contractor must provide Enrollees with a Certificate of Coverage.

b. Contractor must provide MDHHS all new or amended Michigan Department of Insurance and Financial Services (DIFS) approved Medicaid Certificates of Coverage.

G. Provider Directory

1. Contractor must maintain a complete Provider directory. Information included in a paper Provider directory must be updated at least (A) Monthly, if the Contractor does not have a mobile-enabled, electronic directory; or (B) Quarterly, if the Contractor has a mobile-enabled, electronic Provider directory. An electronic Provider directory must be updated no later than 30 calendar Days after the Contractor receives updated Provider information.

2. Contractor must provide the Provider directory in a manner agreeable to the Enrollee either by mail or by utilizing the Contractor's web site. Provider directories must be made available on the Contractor's Web site in a machine-readable file.

a. The Provider electronic directory must be made easily accessible to Enrollees. This means the Provider directory must have a clearly identifiable link or tab and may not require an Enrollee account or policy number to access the directory.

b. Provider directory must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency.

c. Contractor must include, in both electronic and print directories, a customer service email address, telephone number and/or electronic link that individuals may use to notify the Contractor of inaccurate Provider directory information.

3. Contractor's Provider directory must contain, at a minimum, the information listed in Appendix 17 for Network Providers.

    a. If applicable, the Provider directory must include note of prior authorization or referral requirement for certain Providers.

    b. Contractor must periodically audit at least a sample size of its Provider directory for accuracy and retain documentation of such audit to be made available to MDHHS upon request. Directory information for all PCPs, OB/GYNs, hospitals and outpatient mental health Providers must be audited at least annually.

    c. Contractor must indicate which Network Providers who see children under the age of 19 are enrolled in the VFC program.

4. Contractor must maintain full compliance with the office hour information on the 4275 provider file or list days and hours of operation on the PCP listing in the provider directory.

H. Grievance and Appeal Process for Enrollees

1. Grievance and Appeal Policies and Procedures

    a. Contractor must establish and maintain an internal process for the resolution of Grievances and Appeals from Enrollees.

    b. Contractor must have written policies and procedures governing the resolution of Grievances and Appeals; An Enrollee, or a third party acting on behalf of an Enrollee, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal.

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

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

        ii. Contractor must cooperate with the DIFS in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act".

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

        iv. Contractor must make a determination on non-expedited Appeals not later than 30 Days after an Appeal is received from an Enrollee and not later than 10 Days after an Appeal is received from an Enrollee in CSHCS. The 30-Day and 10-Day period may

be tolled; however, for any period of time the Enrollee is permitted to take under the Medicaid Appeals procedure and for a period of time that must not exceed 14 Days if (1) the Enrollee requests the extension or (2) The Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest. The Contractor may not toll (suspend) the time frame for Appeal decisions other than as described in this section.

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

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

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

2. Within two Days provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

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

vii. If an Appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the Beneficiary, the 30-Day or 10-Day timeframe begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the Beneficiary that an authorized representative form or document is required. For purposes of this section, "third party" includes, but is not limited to, health care Providers.

2. Grievance and Appeal Procedure Requirements

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

a. Contractor must give Enrollees timely and adequate notice of an Adverse Benefit determination in writing consistent with the requirements in §438.02, 438.10, 438.404 and this Contract. The notice must explain the following: (1) The Adverse Benefit Determination the Contractor has made or intends to make. (2) The reasons for the Adverse Benefit Determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (3) The Enrollee's right to request an Appeal of the Adverse Benefit Determination, including information on

exhausting the Contractor's one level of Appeal and the right to request a State Fair Hearing. (4) The procedures for exercising their Appeal rights, the circumstances under which an Appeal process can be expedited and how to request it. (5) The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and, if allowed under State policy, the circumstances under which the Enrollee may be required to pay the costs of these services.

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

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

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

e. Contractor must acknowledge receipt of each Grievance and Appeal.

f. Contractor must ensure that the individuals who make decisions on Grievances and Appeals are individuals who:

   i. Are not involved in any previous level of review or decision-making, nor a subordinate of any such individual; and

   ii. Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the Grievance or Appeal involves a clinical issue. When reviewing Appeals for Enrollees in CSHCS, the Contractor must utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate, or limit pediatric subspecialist provider services.

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

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

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

i. Contractor must provide the Enrollee and their representative the Enrollee's case file, including medical records, other documents, and records, and any new or additional evidence considered, relied upon, or

generated by the Contractor in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals.

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

k. Contractor must notify the Enrollee in writing of the Contractor's decision on the Grievance or Appeal.

3. Notice to Enrollees of Grievance Procedure

a. Contractor must inform Enrollees about the Contractor's internal Grievance procedures at the time of Initial Enrollment and any other time an Enrollee expresses dissatisfaction by filing a Grievance with the Contractor.

b. The Appeal procedure information must be included in the member handbook and must explain:

i. How to file a Grievance with the Contractor

ii. The internal Grievance resolution process

4. Notice to Enrollees of Appeal Procedure

a. Contractor must inform Enrollees of the Contractor's Appeal procedure at the time of Initial Enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to Appeal under the definition of Appeal in this Contract.

b. The Appeal procedure information must be included in the member handbook and must explain:

i. How to file an Appeal with the Contractor

ii. The internal Appeal process

iii. The member's right to a Fair Hearing with the State after the Contractor's one level Appeal process has been exhausted.

5. Contractor Decisions Subject to Appeal

a. When the Contractor makes a decision subject to Appeal, as defined in this Contract, the Contractor must provide a written Adverse Benefit determination notice to the Enrollee and the requesting Provider, if applicable. The Contractor must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-Services, within the timeframes specified in 42 CFR §§ 431.211,431.213, and 431.214. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in§ 438.210(d)(1). (4) If the Contractor meets the criteria set forth for

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

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

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

iii. The services were ordered by an authorized Provider.

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

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

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

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

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

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

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

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

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

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

e. If the Contractor or the State Fair Hearing Officer upholds a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the Contractor may recoup over-issuances.

f. Contractor must notify the impacted or requesting provider and give the Enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

6. Adverse Benefit Determination Notice

a. Adverse Benefit determination notices involving Service Authorization Request decisions that deny or limit services must be made within the time frames described in this Contract. Adverse Benefit Determination Notices pursuant to claim denials must be sent on the date of claim denial. For termination, suspension, or reduction of previously authorized Medicaid- Covered Services, Contractor must mail Adverse Benefit Determination Notices within the following timeframes:

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

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

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

2. The Enrollee submits a signed written statement that:

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

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

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

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

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

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

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

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

1. The Contractor has facts indicating that action must be taken because of probable Fraud by the Enrollee; and

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

b. The notice must include the following components:

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

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

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

iv. An explanation of the Contractor's Appeal process.

v. The Enrollee's right to request a Fair Hearing.

vi. How to request a Fair Hearing

vii. The circumstances under which expedited resolution is available how to request it, and the circumstances under which the Enrollee may be required to pay the costs of continued services.

viii. The Enrollee's right to have benefits continue pending resolution of the Appeal, and how to request that benefits be continued.

c. Written adverse action notices must also meet the following criteria:

i. Be translated for the individuals who speak prevalent non-English languages as defined by the Contract.

ii. Include language clarifying that oral interpretation is available for all languages and how the Enrollee can access oral interpretation services.

iii. Use easily understood language written below the 6.9 reading level.

iv. Use an easily understood format.

v. Be available in Alternative Formats, and in an appropriate manner that takes into consideration those with special needs.

7. State Medicaid Appeal Process

a. The State must maintain a Fair Hearing process to ensure Enrollees have the opportunity to Appeal decisions directly to the State. Any Enrollee dissatisfied with a State agency determination denying an Enrollee's request to transfer Contractors/disenroll has access to a State Fair Hearing.

b. Contractor must include the Fair Hearing process as part of the written internal process for resolution of Appeals and must describe the Fair Hearing process in the member handbook. The parties to the State Fair Hearing may include the Contractor as well as the Enrollee and her or his representative or the representative of a deceased Enrollee's estate.

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

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

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

8. Expedited Appeal Process Contractor's written policies and procedures governing the resolution of Appeals must include provisions for the resolution of Expedited Appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:

a. The Enrollee or Provider may file an Expedited Appeal either orally or in writing.

b. The Enrollee or Provider must file a request for an Expedited Appeal within 10 Days of the Adverse Benefit Determination.

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

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

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

f. Contractor must not take any punitive actions toward a Provider who requests or supports an Expedited Appeal on behalf of an Enrollee.

9. Grievance and Appeals Records

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

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

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

ii. The date received

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

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

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

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

vii. Whether the appeal was standard or expedited

viii. Length of time between date received and date of resolution

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

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

d. Contractor must identify CSHCS beneficiaries and CSHCS corresponding Medicaid ID numbers on its Appeals and Grievances records. Contractor must have the ability to report CSHCS Grievance and Appeal records upon request.

XIV. Provider Services

A. Provider Services

1. Contractor must provide contract and education services for the Provider Network, including education regarding Fraud, Waste and Abuse.

2. Contractor must properly maintain medical records.

3. Contractor must process Provider Grievances and Appeals in accordance with contract and regulatory requirements.

4. Contractor must develop and maintain an Appeal system to resolve claim and authorization disputes.

5. Contractor must maintain a written plan detailing methods of Provider recruitment and education regarding Contractor policies and procedures.

6. Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to its Providers. This may include guidelines for answering written correspondence to Providers, offering Provider-dedicated phone lines, or a regular provider newsletter.

7. Contractor must provide a staff of sufficient size to respond timely to Provider inquiries, questions, and concerns regarding Covered Services.

8. Contractor must provide a copy of the Contractor's prior authorization policies to the Provider when the Provider joins the Contractor's Provider Network. Contractor must notify Providers of any changes to prior authorization policies as changes are made.

9. Contractor must make available Provider policies, procedures, and Appeal processes via Contractor website. Updates to the policies and procedures must be available on the website as well as through other media used by the Contractor.

10. Contractor must provide Network Providers with information on CSHCS, including contact information for a designated staff member employed by the Contractor who can address Provider questions about care provided to Enrollees in CSHCS.

B. Provider Contracts

Contractor must comply with the following provisions and include the following information in Provider Contracts:

1. Prohibit the Provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract and require the Provider to look solely to the Contractor for compensation for services rendered.

2. Require the Provider to cooperate with Contractor's quality improvement and utilization review activities.

3. Include provisions for the immediate transfer of Enrollees to another Contractor PCP if their health or safety is in jeopardy.

4. Include provisions stating that Providers are not prohibited from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.

5. Include provisions stating that Providers, acting within the lawful scope of practice, are not prohibited, or otherwise restricted, from advising or advocating on behalf of an Enrollee who is their patient:

   a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

   b. For any information the Enrollee needs in order to decide among all relevant treatment options.

   c. For the risks, benefits, and consequences of treatment or non-treatment.

   d. For the Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6. Require Providers to meet Medicaid accessibility standards as defined in this Contract.

7. Provide for continuity of treatment in the event a Provider's participation terminates during the course of a member's treatment by that Provider.

8. If the Contractor utilizes copayments for the Covered Service, prohibit the Provider from denying services to Enrollee's based on their inability to pay the copayment.

9. Ensure hospital contracts contain a provision that mandates the hospital to comply with all medical record requirements contained within (42 CFR 456.101-145).

10. Require Providers to take Enrollees' rights into account when providing services as outlined in 42 CFR 438.100.

11. Ensure Enrollees are not denied a Covered Service or availability of a facility or Provider identified in this Contract.

12. Require Providers to not intentionally segregate Enrollees in any way from other persons receiving health care services.

13. Require health professionals to comply with reporting requirements for communicable disease and other health indicators as mandated by State law.

C. Provider Participation

1. Contractor must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of Provider's license or certification under applicable State law, solely on the basis of such license or certification and must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

2. This provision should not be construed as an "any willing provider" law, as it does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Enrollees.

3. This provision does not interfere with measures established by the Contractor designed to maintain quality and control costs consistent with the responsibility of the organization.

4. If Contractor declines to include Providers in-network, the Contractor must give the affected providers written notice of the reason for the decision.

D. Provision of Grievance, Appeal and Fair Hearing Procedures to Providers

Contractor must provide the following Enrollee Grievance, Appeal, and fair hearing procedures and timeframes to all Providers and Subcontractors at the time they enter into a contract:

1. The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing.

2. The Enrollee's right to file Grievances and Appeals and their requirements and timeframes for filing.

3. The availability of assistance to the Enrollee in filing.

4. The toll-free numbers to file oral Grievances and Appeals.

5. The Enrollee's right to request continuation of benefits during an Appeal or State Fair Hearing filing and that if the Contractor's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

E. Provider Credentialing and Recredentialing

Contractor must comply with the requirements of MCL 500.3528 and 42 CFR 438.214 regarding the credentialing and recredentialing of Providers within the Contractor's Provider Network, including but not limited to the requirements specified in this section. Contractor must implement written policies and procedures for selection and retention of Network Providers that meet uniform credentialing and recredentialing policies established by MDHHS. Contractor must follow a documented process for credentialing and recredentialing of Network Providers.

MDHHS intends to standardize and potentially centralize the credentialing and recredentialing process. Contractor acknowledges MDHHS' intent and commits to participating in activities necessary to ensure the successful implementation of a standardized and potentially centralized credentialing process, including but not limited to: stakeholder engagement initiatives, implementation planning activities, and compliance with current and future MDHHS credentialing policies and processes.

1. Contractor must have written credentialing and recredentialing policies and procedures that do the following:

a. Ensure quality of care.

b. Ensure that all Providers rendering services to Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract.

c. Verify that the Provider is not debarred or suspended by any State or federal agency.

d. Require the Provider to disclose criminal convictions related to federal health care programs.

e. Review the Provider's employees to ensure that these employees are not debarred or suspended by any state or federal agency.

f. Require the Provider's employees to disclose criminal convictions related to federal health care programs.

g. Allow Providers to request retroactive effective date for network participation back to date of receipt of complete credentialing application.

h. Ensure compliance with all provider enrollment background and screening requirements as required by the Medicaid program.

2. Recredentialing

a. Contractor must recredential Providers at least every three years.

b. Contractor must ensure that Network Providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state.

c. Contractor must maintain written policies and procedures for monitoring its Providers and for sanctioning Providers who are out of compliance with the Contractor's medical management standards.

F. Payment to Providers

1. Timely Payments

Contractor must make timely payments to all Providers for Covered Services rendered to Enrollees as required by 42 CFR 447.45 and MCL 400.111i and in compliance with established MDHHS performance standards.

a. Contractor must pay 95 percent of all Clean Claims from practitioners within 30 Days of the date of receipt.

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

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

d. Contractor must have ≤1% of ending inventory over 45 Days old and ≤12% denied claims.

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

f. Upon request from MDHHS, the Contractor must develop programs for improving access, quality, and performance with Providers. Such programs must include MDHHS in the design methodology, data collection, and evaluation.

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

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

i. Contractor is responsible for annual IRS form 1099, Reporting of Provider Earnings, and must make all collected data available to MDHHS and, upon request, to CMS.

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

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

l. Contractor must conduct an internal review of all denied claims for beneficiaries with a current Foster Care indicator and report denial reasons to MDHHS upon request.

2. Electronic Billing Capacity

a. Contractor must meet the HIPAA and MDHHS guidelines and requirements for electronic billing capacity and may require its Providers to meet the same standard as a condition for payment.

b. Contractor must ensure Providers bill the Contractor using the same format and coding instructions required for the Medicaid FFS programs according to Medicaid Policy.

c. Contractor must not require Providers to complete additional fields on the electronic forms not specified in Medicaid FFS Policy.

d. Contractor may require additional documentation, such as medical records, to justify the level of care provided.

e. Contractors may require prior authorization for services for which the Medicaid FFS program does not require prior authorization except where prohibited by other sections of this Contract or Medicaid policy.

f. Contractor must maintain the completeness and accuracy of their websites regarding this information.

3. Provider Preventable Conditions

a. Contractor is prohibited from making payment to a Provider for provider preventable conditions

i. That are outlined in the Michigan State Plan;

ii. Has a negative consequence for the beneficiary

iii. Is auditable;

iv. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, surgical or other invasive procedure performed on the wrong patient.

b. Contractor must require all Providers to report provider-preventable conditions associated with claims for payment or Enrollee treatment for which payment would otherwise be made in accordance with federal Medicaid regulations.

c. Contractor must report all identified provider-preventable conditions as directed by MDHHS.

4. Post-Payment Review

a. Contractor must utilize a post-payment review methodology to assure claims have been paid appropriately.

b. Contractor must complete post-payment reviews for individuals retroactively disenrolled by MDHHS for incarceration or placement in a nursing facility within 90 Days of the date MDHHS notifies the Contractor of the retroactive disenrollment. These disenrollments are identified with disenrollment reason code I and N, respectively, on the 5790 834 daily enrollment file.

c. Contractor must not recoup money from Providers for individuals retroactively disenrolled for incarceration or placement in a nursing facility by MDHHS more than 180 Days from the date that MDHHS notified the Contractor of the retroactive disenrollment.

d. Contractor must complete post-payment reviews for individuals disenrolled by MDHHS due to death within 90 Days of the date MDHHS notifies the Contractor of the Enrollee's death or within 90 Days of the date MDHHS notifies the Contractor of disenrollment from the plan (if disenrollment notification is after notification of death). Disenrollments due to Death are identified with disenrollment reason code D on the 5790 834 daily enrollment file.

e. For retroactive disenrollments due to loss of eligibility or other unspecified reason, the Contractor must not automatically recoup payments made to providers; these disenrollments are identified with disenrollment reason code L and O, respectively, on the 5790 834 daily enrollment file. Recoupment of the capitation from the Contractor is based on several eligibility and enrollment factors that may change after the Enrollee is disenrolled. Contractors may not recoup from providers unless MDHHS recoups the capitation payment from the Contractor and does not reimburse the Contractor for the recouped capitation amount.

i. If the Enrollee is retroactively disenrolled due to loss of Medicaid eligibility and regains Medicaid eligibility within two months, the Enrollee will be retroactively reenrolled to the same Contractor (See Section 1.1.IV. C. 2). MDHHS will not recoup the capitation payment from the Contractor for the retroactive time period and the Contractor is prohibited from recouping payments from providers.

ii. If an Enrollee is retroactively disenrolled due to retroactive loss of eligibility in error, when the eligibility is corrected, MDHHS will send a replacement enrollment to the Contractor when the eligibility is corrected (See Section 1.1.IV.H.3). MDHHS will not recoup the capitation payment from the provider for the retroactive time period and the Contractor is prohibited from recouping payments from providers.

iii. If an Enrollee properly loses full Medicaid eligibility but the loss of eligibility is not appropriately processed by CHAMPS until a subsequent month, the Enrollee will have a time period of enrollment in the Contractor's plan that is not supported by Medicaid eligibility. MDHHS will recoup capitation payments made for all months that are not supported by Medicaid eligibility. If the Contractor has paid for services during the months not supported by eligibility, MDHHS will process a gross adjustment, without utilizing Medicaid funding, in the amount of the recouped capitation payment. The Contractor is prohibited from recouping payments from providers.

5. Payment Resolution Process

a. Contractor must develop and maintain an effective Provider Appeal process to promptly resolve Provider billing disputes and other issues.

b. Contractor must cooperate with Providers who have exhausted the Contractor's Appeal process by entering into arbitration or other alternative dispute resolution process.

6. Arbitration and Rapid Dispute Resolution

a. Contractor must comply with the provisions of the Hospital Access Agreement executed by MDHHS and the hospitals.

b. To resolve claim disputes with non-contracted hospital providers, the Contractor must follow the Rapid Dispute Resolution Process specified in the Medicaid Provider Manual. This applies solely to disputes with noncontracted hospital providers that have signed the Hospital Access Agreement; noncontracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution Process. At MDHHS direction, Contractor must go through the Rapid Dispute Resolution Process.

c. When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, the Contractor is required to participate in a binding arbitration process. Providers must exhaust the Contractor's internal provider Appeal process before requesting arbitration.

d. MDHHS will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid.

Both parties agree to assume the burden of cost for presentation of their positions before the mediator.

7. Enrollee Liability for Payment

The Enrollee must not be held liable by Contractor or Contractor's Providers for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR 438.116 (i.e., prohibition on balance billing the Enrollee):

a. Debts of the Contractor, in case of insolvency.

b. Covered Services under this Contract provided to the Enrollee for which MDHHS did not pay the Contractor.

c. Covered Services provided to the Enrollee for which MDHHS or the Contractor does not pay the Provider due to contractual, referral or other arrangement.

d. Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.

8. Hospital Payments

a. Contractor must pay Out-of-Network hospitals for all emergency and authorized Covered Services provided to the Contractor's Enrollee(s) outside of the Contractor's Provider Network.

i. Out-of-Network hospital claims must be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid providers.

ii. Hospital payments must include payment for the DRG (as defined in the Medicaid Institutional Provider Chapter) outliers, as applicable, and capital costs at the per-discharge rate.

iii. Hospital payments must include the applicable hospital reimbursement (e.g., Graduate Medical Education) in the amount and on the schedule defined by MDHHS.

b. Upon request from MDHHS, Contractor must develop programs for improving access, quality, and performance with both network and Out-of-Network hospitals in Collaboration with MDHHS in the design methodology, data collection, and evaluation and make all payments to both network and Out-of-Network hospitals defined by the methodology jointly developed by the Contractor and MDHHS.

9. Family Centered Medical Home

Contractor must make the following Per Member Per Month payments to contracted Primary Care Providers who serve Enrollees in CSHCS:

a. $4 to each Primary Care Provider serving a TANF Enrollee in CSHCS

b. $6 to each Primary Care Provider serving an HMP Enrollee in CSHCS

c. $8 to each Primary Care Provider serving an ABAD Enrollees in CSHCS

10. Fee Schedule for Primary Care Practitioner Services

Contractor must provide increased payments to eligible Primary Care Providers rendering specific primary care services to Enrollees. Refer to Medicaid Policy for allowable codes.

11. Electronic Visit Verification (EVV)

Contractor shall collaborate with the Department and its selected vendor to comply with the Electronic Visit Verification (EVV) requirements as contained in Section 12006 of the 21st Century Cures Act and Section 1903 (l) of the Social Security Act.

12. Fee Schedule for Providers in the VFC Program

Contractor must reimburse Providers who are also enrolled in the State's VFC program for vaccine administration at a rate no less than one established by MDHHS.

13. Providers Seeing Children in Foster Care within the First 30 Days of Entering Foster Care

Contractor must reimburse Providers for a well-child visit, inclusive of a full medical examination and all appropriate developmental and mental health screenings and assessments, in children and youth within the first 30 Days of entering foster care.

XV. Management Information Systems

A. Management Information System (MIS) Capabilities

Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by 42 CFR 438.242 and MDHHS. The system must provide information on areas including but not limited to, utilization, claims, Grievances and Appeals, and disenrollments for other than loss of Medicaid eligibility. Contractor must develop, implement, and maintain policies and procedures that describe how the Contractor will comply with the requirements of this section. The information system must have the capability for:

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

2. Supporting Provider payments and data reporting between the Contractor and MDHHS.

3. Controlling, processing, and paying Providers for services rendered to Enrollees.

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

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

    a. Member enrollment, disenrollment, and Capitation Payments, including the capability of reconciling enrollment and Capitation Payments received

    b. Utilization

    c. Care management

    d. Provider enrollment

    e. Third Party Liability (TPL) activity

    f. Claims payment

    g. Grievance and Appeal tracking, including the ability to stratify Grievance and Appeal by population and track separately (e.g., Enrollees in CSHCS)

6. Collecting income, group composition and FPL information for HMP Enrollees

7. Collecting and tracking Enrollee-specific healthy behavior and goal information for HMP Enrollees and providing information to MDHHS in the specified format

B. Enrollment and Payment Files

MDHHS will provide HIPAA-compliant daily and monthly enrollment files to the Contractor via the File Transfer Service (FTS).

1. Contractor's MIS must have the capability to utilize the HIPAA-compliant enrollment files to update each Enrollee's status on the MIS including Enrollee income, group composition and federal poverty level information for HMP Enrollees.

2. Contractor must load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's vendors (e.g., pharmacy, vision, mental health, DME) on or before the first of the month so that Enrollees have access to services.

3. Contractor must reconcile the daily and monthly (4976) enrollment files to the monthly payment file within 120 Days of the end of each month.

    a. In the event that an issue or error with enrollment files becomes known, MDHHS will communicate the issue, status and working resolution with the Contractor.

    b. Should the issue or error affect the Contractor's ability to reconcile enrollment files, MDHHS will communicate appropriate workarounds, operational revisions or revise deliverable requirements as appropriate to the outstanding issue or error.

4. Contractor must ensure that MIS support staff have sufficient training and experience to manage files MDHHS sends to the Contractor via the FTS.

C. Data Accuracy

1. Contractor must ensure all Encounter Data is complete and accurate for the purposes of rate calculations and quality and Utilization Management.

2. Contractor must provide for collection and maintenance of sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees.

3. Contractor must ensure data received from Providers is accurate and complete by:

    a. Verifying the accuracy and timeliness of the data, including data from Network Providers the Contractor is compensating on the basis of Capitation Payments.

    b. Screening the data for completeness, logic, and consistency

    c. Collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

    d. Identifying and tracking Fraud, Waste and Abuse

4. Contractor must make all collected data available to MDHHS and upon request to CMS, including submission of all Enrollee Encounter Data that MDHHS is required to report to CMS under § 438.818.

D. Automated Contact Tracking System

Contractor must utilize the MDHHS Automated Contact Tracking System to submit the following requests:

1. Disenrollment requests for out of area Enrollees who appear in the wrong county on the Contractor's enrollment file.

2. Requests for newborn enrollment for out-of-state births or births for which MDHHS does not notify the Contractor of the newborn's enrollment within two months of the birth.

3. Maternity Case Rate (MCR) Invoice Generation request for births for which the Contractor has not received an MCR payment within three months of the birth.

4. Other administrative requests specified by MDHHS.

E. Provider Network File (4275)

1. Provider Network files are used by the Enrollment Broker to convey information to beneficiaries on available Contractors and Network Providers for each Contractor.

2. MDHHS utilizes the 4275 to ensure the Provider Networks identified for Contractors are adequate in terms of number, location, and hours of operation.

3. Contractor must submit Provider files that contain a complete and accurate description of the Provider Network available to Enrollees according to the specifications and format delineated by MDHHS to the MDHHS Enrollment Services Contractor.

4. The 4275 file must contain all contracted Providers.

5. Contractor must submit a Provider file that passes all MDHHS quality edits to the MDHHS Enrollment Services Contractor at least once per month and more frequently, if necessary, to ensure changes in the Contractor's Provider Network are reflected in the Provider file in a timely manner.

F. PCP Submission File (5284)

1. Contractor must submit 5284 files containing PCP additions, changes, or deletions at least weekly.

2. Contractor must submit the addition, change or deletions within 10 Business Days of the PCP assignment or change.

3. Contractor must submit a complete 5284 file showing all PCP assignments when requested by MDHHS.

G. Network Adequacy Provider (NAP) File

1. NAP files are used by MDHHS to determine the Contractor's Provider network has a sufficient number of providers located within the contracted Service Area.

2. MDHHS utilizes the NAP file to ensure the Provider Networks identified for Contractors are adequate in terms of number, location, and hours of operation.

3. Contractor must submit NAP files that contain a complete and accurate description of the Provider Network according to the specifications and format delineated by MDHHS.

4. The NAP file must contain all contracted Providers, including all providers that are contracted through a Subcontractor of the Contractor (e.g. dental subcontractor, Pharmacy Benefits Manager, etc.).

5. Contractor must submit a NAP file that passes all MDHHS quality edits at least once per month and more frequently, if necessary, to ensure changes in the Contractor's Provider Network are reflected in the NAP file in a timely manner.

XVI. Health Information Exchange/Health Information Technology

Contractor must support MDHHS initiatives to increase the use of Health Information Exchange and Health Information Technology (HIE/HIT) to improve care management and coordination; reduce Fraud, Waste and Abuse; and improve communication between systems of care. MDHHS reserves the right to revise requirements specified in this section regarding HIE/HIT. This may include, but is not limited to, requirements that the Contractor must implement and maintain electronic data system that would support common information exchange with providers and CBOs and further MDHHS community information exchange strategy. The Contractor must take all necessary actions to comply with any updated requirements from MDHHS.

A. Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

MDHHS has established rules and guidelines to advance the adoption and meaningful use of certified EHR technology through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH).

1. Contractor must comply with MDHHS performance programs designed to advance provider adoption and meaningful use of certified EHR.

2. Contractor must assist MDHHS in statewide efforts to target high-volume Medicaid Providers eligible for the EHR incentive payments.

3. Contractors are encouraged to align Provider incentives with meaningful use objectives and measures and clinical quality measure reporting.

4. Contractor must promote the EHR Incentive Programs as part of regular Provider communications.

5. Contractor must electronically exchange eligibility and claim information with Providers to promote the use of EHR.

B. Electronic Exchange of Client-Level Information

1. Contractor must implement and maintain an electronic data system, by which Providers and other entities can send and receive client-level information for the purpose of care management and coordination.

2. The electronic data system must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations.

3. Contractor must ensure LHDs and CMDS clinics that provide and coordinate services for Enrollees in CSHCS to have the ability to exchange real-time client-level information for the purpose of care management and coordination.

4. Contractor must ensure PIHPs that provide mental health services to Enrollees have the ability to exchange real-time client-level information for the purpose of care management and coordination and reporting quality metrics.

5. Contractor must ensure capacity to, at a minimum, receive admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination response hospital admissions and readmissions at the plan level and within its provider network.

6. Contractor must ensure capabilities to collect, store, and incorporate clinical quality information into their provider quality measurement and improvement programs to enhance the health plan's capacity to measure and improve the clinical health outcomes of their members. The proportion of their total provider network and membership used to meet this requirement will be established by the Contractor.

XVII. Emergency Management Plan

A. Business Continuity and Disaster Recovery Plan

The Contractor must submit to the Department a Business Continuity and Disaster Recovery (BC-DR) Plan specifying what actions the Contractor must conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency, including but not limited to localized acts of nature, accidents, and technological and/or attack-related emergencies.

1. Regardless of the architecture of its systems, the Contractor must develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan must limit service interruption to a period of twenty-four (24) hours and must ensure compliance with all contractual requirements. The records backup standards and the BC-DR plan must be developed and maintained for the entire Contract period.

2. The BC-DR plan must include a strategy for restoring day-to-day operations, including alternative locations for the Contractor to operate. The BC-DR plan must maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction. The Contractor's BC-DR plan must be submitted to the Department annually. If the approved plan is unchanged from the previous year, the Contractor must submit a certification to the Department that the prior year's plan is still in place (date) of each Contract year. Changes in the plan are due to the Agency within ten (10) Business Days after the change.

3. In the event that the Contractor fails to demonstrate restoration of system functions per the standards outlined in this Contract, the Contractor shall be required to submit to the Department a CAP in accordance with Section 1.1.XX. Contract Compliance Reviews, Non- Compliance, that outlines how the failure shall be resolved.

B. BC-DR Plan Inclusion

At a minimum, the BC-DR plan must contain the following:

1. Essential roles, responsibilities, and coordination efforts necessary to support recovery and business continuity.

2. Risk assessment procedures to comply with this Contract during disasters.

3. Procedures for data backup, disaster recovery including restoration of data, and emergency mode operations.

4. Procedures to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency.

5. Procedures for emergency access to electronic information.

6. Communication plan specific to enrollees and providers during disasters, and policies and procedures provided to plan staff.

   a. Specific communication plans must be shared with the Department whenever an emergency situation occurs.

   b. Contractor must publish guidance via website for enrollees and providers before, during, and after an emergency on how to receive services, contact information for emergencies, payment processes and any other information required by the Department.

   c. Contractor must conduct member outreach including daily communication efforts to reach members with mental health needs, high risk needs, special healthcare needs and those with health care needs which are electricity dependent. Communications include SMS text messaging and incoming calls to member and provider call centers.

   d. Contractor must conduct provider outreach including daily communications to identify issues such as closures and re-openings, power outages, and evacuations.

C. BC-DR Required Scenarios

At a minimum, the Contractor’s BC-DR plan must address the following scenarios:

1. The central computer installation and resident software are destroyed or damaged;

2. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

3. System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and

4. Malicious acts, including malware or manipulation.

D. Disaster Declaration

The Contractor must comply with the following provisions when a disaster is declared by a Governor's Executive Order and confirmed by the Department:

1. Furnish covered services to an enrollee without any form of authorization, without regard to whether such services are provided by a participating or non-participating provider, and without regard to service limitations.

2. Implement a readily available claims payment process to ensure providers are paid for services rendered before, during, and after the disaster, as medically necessary.

XVIII. Observance of State and Federal Laws and Regulations

A. General

1. Contractor must comply with all State and federal laws, statutes, regulations, and administrative procedures and implement any necessary changes in policies and procedures as required by MDHHS.

2. Federal regulations governing contracts with risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 42 CFR Part 438 and will govern this Contract.

3. The Contractor and the State are subject to the federal and State conflict of interest statutes and regulations that apply to the Contractor under this Contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423): 18 U.S.C. 207)): 18 U.S.C. 208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222.

4. Contractor is prohibited from making payment as applicably restricted in Section 1903(i) of the Social Security Act.

5. Centers for Medicare & Medicaid Services (CMS) has granted MDHHS a waiver under Section 1915(b)(1)(2) of the Social Security Act, granting the State a waiver of Section 1902 (a)(23) of the Social Security Act. Under this waiver, beneficiaries will be enrolled with a Contractor in the county of their residence. All health care for Enrollees will be arranged for or administered by the Contractor. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this Contract.

6. The Contractor and the State are subject to comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs

and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

7. A Contractor that elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, must furnish information about the services it does not cover to MDHHS:

    a. With its application for a Medicaid contract;

    b. Whenever it adopts such a policy during the term of the contract.

B. Fiscal Soundness of the Risk-Based Contractor

Federal regulations (42 CFR 438.116) require that the risk-based Contractors maintain a fiscally solvent operation.

1. Contractor must comply with all HMO statutory requirements for fiscal soundness and MDHHS will evaluate the Contractor's financial soundness based upon the thresholds established in Appendix 2 of this Contract.

2. If the Contractor does not maintain the minimum statutory financial requirements, MDHHS will apply remedies and Sanctions as specified in this Contract, including termination of the Contract.

3. Contractor must maintain financial records for its Medicaid activities separate from other financial records.

C. Accreditation/Certification Requirements

1. Contractor must hold and maintain accreditation as a managed care organization by the NCQA or URAC Accreditation for Health Plans.

2. If Contractor is accredited by NCQA, Contractor must pursue MED Module Certification. Contractor must be certified no later than October 1, 2025.

3. Contractor must hold and maintain NCQA Health Equity Accreditation in the State of Michigan. Any Contractor not currently accredited in the State of Michigan prior to 10/1/2024 must obtain accreditation within two years of contract start date or upon a separately agreed on timeframe at the sole discretion of MDHHS (see Section 1.1.XX.A.3.m). Contractor must also provide the State information regarding the Contractor's progress in achieving Health Equity Accreditation upon the State's request.

    a. The Contractor must provide the State with evidence of the Contractor's Health Equity Accreditation, including the results of the Contractor's most recent NCQA review. The Contractor shall authorize NCQA to provide the State a copy of the most recent Health Equity Accreditation review for the Contractor.

4. Contractor must be incorporated within the State of Michigan and have a Certificate of Authority to operate as a Health Maintenance Organization (HMO)

in the State of Michigan in accordance with MCL 500.3505 (see Section 1.1.XX.A.3.n.).

D. Compliance with False Claims Acts

Contractor must comply with all applicable provisions of the federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and State laws specifically include, but are not limited to, the following:

1. Establish and disseminate written policies for employees of the entity (including managing employees) and any contractor or Agent of the entity regarding the detection and prevention of Fraud, Waste and Abuse.

    a. If the Contractor should defer any contractual requirement (or any process that lends to a contractual requirement) relating to the detection and prevention of Fraud, Waste and Abuse to a subcontractor or agent, it is the Contractor's responsibility to maintain a contract agreement that outlines the specific program integrity responsibilities and/or maintain written policies and procedures that reiterate the conditions of this Contract.

2. The written policies must include detailed information about the federal False Claim Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act.

3. The written policies must specify the rights of employees to be protected as whistleblowers.

4. The written policies must also be adopted by the Contractor's contractors or Agents. A "contractor" or "Agent" includes any contractor, Subcontractor, Agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid healthcare items or services, performs billing or coding functions, or is involved in monitoring of healthcare provided by the entity.

5. If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees regarding detection and prevention of Fraud, Waste and Abuse including an explanation of the false claims acts and of the rights of employees to be protected as whistleblowers.

E. Protection of Enrollees against Liability for Payment and Balanced Billing

1. Contractor must not balance-bill the Enrollee pursuant to Section 1932(b)(6) of the Social Security Act protecting Enrollees from certain payment liabilities. Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to Providers in the case of services provided to an individual enrolled with a Contractor that charges a rate in excess of the rate permitted under the organization's Contract.

F. Physician Incentive Plan

1. Contractor must disclose to MDHHS, upon request, the information on their Provider incentive plans listed in 42 CFR 422.208 and 422.210, as required in 42 CFR 438.6(h).

2. Contractor's incentive plans must meet the requirements of 42 CFR 422.208-422.210 when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903(s) of the Social Security Act.

3. If Contractor puts a physician/ physician group at substantial financial risk for services not provided by the physician/ physician group, the Contractor must ensure that the physician/ physician group has adequate stop-loss protection.

4. Upon request, the Contractor must provide the information on its Physician Incentive Plans listed in 42 CFR 422.208 and 422.210 to any Enrollee.

G. Third Party Resource Requirements

Third Party Liability (TPL) refers to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the approved Medicaid state plan. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to be made whole, including recoveries from any related court judgment or settlement if Contractor has been notified of the legal action. Contractor must follow the "Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing" as described in the Michigan State Medicaid Plan, Attachment 4.22-B, Page 1. Contractor may pursue cases below the thresholds at their discretion.

1. Contractor must seek to identify and recover all sources of third-party funds based on industry standards and those outlined by MDHHS TPL Division.

2. Contractor may retain all such collections. If third party resources are available and liability has been established, the Contractor is required to follow Medicaid policy, guidance, and all applicable state and federal statutes, the Medicaid Provider Manual, the State Plan, and the TPL Guidelines and Best Practices Guidance for cost avoiding Medicaid covered services.

3. Contractor must follow Medicaid Policy, guidance and all applicable state and federal statutes regarding TPL. MDHHS TPL policy information can be found in federal regulations, Michigan Compiled Law, MDHHS Medicaid Provider Manual, the State Plan, and TPL Guidelines, and are available upon request. Contractor use of best practices is strongly encouraged by MDHHS and are available in the TPL Guidelines and Best Practices Guidance. Contractor must develop and implement written policies describing its procedures for TPL recovery. MDHHS will review Contractor's policies and procedures for compliance with this contract and for consistency with TPL recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.

4. Contractor must report third party collections through Encounter Data submission and in aggregate as required by MDHHS.

5. Throughout the Contract term, Contractor must comply in full with the provision of third party recovery data to MDHHS in the electronic format prescribed by

MDHHS. Recovery data must be submitted on a quarterly basis. Activities performed October through December will be reported by February 15; activities performed January through March reported by May 15; activities performed April through June reported by August 15; and activities performed July through September reported by November 15.

6. Contractor must collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D. Upon MDHHS identification of missed collections, potential rate or retrospective adjustments may occur.

7. MDHHS will provide the Contractor with all known third party resources for its Enrollees. This information is available real-time within CHAMPS or through 270 requests. MDHHS will provide the most recent data to Contractor on the daily 834 HIPAA compliant enrollment file. MDHHS will provide Contractor with a full history of known third party resources for Enrollees through a secure file transfer process.

8. If Contractor denies a claim due to third party resources (other insurance), the Contractor must provide the other insurance carrier ID, if known, to the billing provider.

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

10. Contractor must respond within 30 Days of subrogation notification pursuant to MCL 400.106 (10).

11. Contractor must cooperate with TPL subrogation best practices including but not limited to:

    a. Provide MDHHS with most recent contact information of Contractor's assigned TPL staff including staff name(s), fax, and telephone numbers. Contractor must inform MDHHS in writing within 14 Days of vacancy or staffing change of assigned TPL staff.

    b. Record and report TPL quarterly subrogation activities to MDHHS on a template developed by MDHHS.

    c. Contractor is prohibited from recovering loss directly from the beneficiary.

H. Marketing

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

1. Contractor must comply with the Marketing, branding, incentive, and other relevant guidelines and requirements established by MDHHS, State, and 42 CFR § 438.104.

2. Contractor may provide incentives, consistent with State law, to Enrollees that encourage healthy behavior and practices.

3. Contractor must secure MDHHS approval for Marketing Materials and Health Fairs prior to implementation as outlined in the MDHHS Marketing/Branding/Incentive Guidelines for Medicaid Health Plans.

    a. Upon receipt by MDHHS of a complete request for approval that proposes allowed Marketing practices and locations, MDHHS will provide a decision to the Contractor within 15 Business Days of the Contractor's request. The review clock will be tolled while the Contractor revises materials for resubmission.

4. Contractor must not provide inducements to beneficiaries or current Enrollees through which compensation, reward, or supplementary benefits or services are offered to enroll or to remain enrolled with the Contractor.

5. Direct Marketing to individual beneficiaries not enrolled with the Contractor is prohibited. For purposes of oral or written Marketing Material, and contact initiated by the Beneficiary, the Contractor must adhere to the following guidelines:

    a. Contractor may only provide factual information about the Contractor's services and contracted Providers.

    b. Contactor must not make any assertions or statements that the recipient must enroll in the Contractor's MHP in order to obtain benefits or not to lose benefits.

    c. Contractor must not make any assertions or statements that the MHP is endorsed by CMS, the Federal or state government, or a similar entity.

    d. If the Enrollee requests information about services, the Contractor must inform the Enrollee that all MHPs are required, at a minimum, to provide the same services as the Medicaid FFS.

    e. Contractor must not make comparisons with other Contractors.

    f. Contractor must not discuss enrollment, disenrollment, or Medicaid eligibility, except as allowed for assistance to current members with the redetermination process; the Contractor must refer all such inquiries to the State's enrollment broker.

6. Examples of Allowed Marketing Locations and Practices Directed at the General Population:

    a. Newspaper articles

    b. Newspaper advertisements

c. Magazine advertisements

d. Signs

e. Billboards

f. Pamphlets

g. Brochures

h. Radio advertisements

i. Television advertisements

j. Online advertising

k. Social media

l. Non-capitated plan sponsored events

m. Public transportation (e.g., buses, taxicabs)

n. Mailings to the general population

o. Health Fairs for Enrollees

p. Malls or commercial retail establishment

q. Community centers, schools, and daycare centers.

r. Churches

7. Prohibited Marketing Locations/Practices that Target Individual Beneficiaries:

a. Local MDHHS offices

b. Provider offices, clinics, including but not limited to, WIC clinics, with the exception of window decals that have been approved by MDHHS.

c. Hospitals

d. Check cashing establishments

e. Door-to-door Marketing

f. Telemarketing, text messaging, e-mail, or other cold-call marketing activities

g. Direct mail targeting individual Medicaid Beneficiaries not currently enrolled in the Contractor's plan.

h. The prohibition of Marketing in Provider offices includes, but is not limited to, written materials distributed in the Providers' office.

i. Contractor must not assist Providers in developing Marketing Materials designed to induce beneficiaries to enroll or to remain enrolled with the Contractor or not disenroll from another Contractor.

j. Contractor may provide decals to participating Providers which can include the health plan name and logo. These decals may be displayed in the Provider office to show participation with the health plan. All decals must be approved by MDHHS prior to distribution to Providers.

I. Health Fairs

1. Contractor may provide an approved plan logo to participating Providers for use on Providers website to show participation with the health plan. All logos must be approved by MDHHS prior to distribution to Providers.

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

a. Organized by an entity other than an MHP, such as, a local health department, a community agency, or a Provider, for Enrollees and the general public. A health fair may be organized by an MHP only if MDHHS has approved the event.

b. Conducted in a public setting, such as a mall, a church, or a local health department. If the health fair is held in a Provider office, all patients of the Provider must be invited to attend. Health screenings may be provided as long as all participants in the health fair have the opportunity to be screened.

c. Beneficiary attendance is voluntary; no inducements other than incentives approved by MDHHS under this Contract may be used to encourage or require participation.

d. Advertisement of the health fair must be directed at the general population, be approved by MDHHS, and comply with all other applicable requirements. A Contractor's name may be used in advertisements of the health fair only if MDHHS has approved the advertisement.

e. The purpose of the health fair must be to provide health education and/or promotional information or material, including information about managed care in general.

f. No direct information may be given regarding enrollment, disenrollment or Medicaid eligibility. If a Beneficiary requests such information during the health fair, the Contractor must instruct the Beneficiary to contact the State's enrollment broker.

g. No comparisons may be made between Contractors, other than by using material produced by a State Agency, including but not limited to, the MDHHS Quality Check-Up.

J. Confidentiality

In addition to the requirements set forth in the Contract terms and related Schedules, including Schedule E, Data Security requirements:

1. Contractor must comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); this includes the designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.

2. All Enrollee information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by the Contractor from unauthorized disclosure.

3. Contractor must provide safeguards that restrict the use or disclosure of information concerning Enrollees to purposes directly connected with its administration of the Contract.

4. Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services.

K. Medical Records

1. Contractor must ensure its Providers maintain medical records of all medical services received by the Enrollee. The medical record must include, at a minimum:

   a. A record of outpatient and emergency care

   b. Specialist referrals

   c. Ancillary care

   d. Diagnostic test findings including all laboratory and radiology,

   e. Prescriptions for medications,

   f. Inpatient discharge summaries,

   g. Histories and physicals,

   h. Immunization records,

   i. And other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

2. Contractor's medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment.

   a. Medical records must be signed and dated.

   b. All medical records must be retained for at least 10 years.

3. Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely

manner, are readily accessible, and permit prompt and systematic retrieval of information.

4. Contractor must have written plans for providing training and evaluating Providers' compliance with the recognized medical records standards.

5. Contractor must have written policies and procedures to maintain the confidentiality of all medical records.

6. Contractor must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information.

7. MDHHS and/or CMS must be given prompt access to all Enrollees' medical records – without written approval from an Enrollee – before requesting an Enrollee's medical record.

8. When an Enrollee changes PCP, the former PCP must forward the Enrollee's medical records or copies of medical records to the new PCP within 10 working Days from receipt of a written request.

L. Advanced Directives Compliance

1. Contractor must comply with all provisions for Advance Directives (described in 42 CFR 422.128) as required in 42 CFR 438.6.

2. Contractor must have in effect, written policies and procedures for the use and handling of Advance Directives written for any adult individual receiving medical care by or through the Contractor. The policies and procedures must include at least the following provisions:

a. The Enrollee's right to have and exercise Advance Directives under the law of the State of Michigan, (MCL 700.5506-700.5512 and MCL 333.1051-333.1064)

b. Changes to laws pertaining to advanced directives must be updated in the policies no later than 90 Days after the changes occur, if applicable

c. Contractor's procedures for respecting advanced directives rights, including any limitations if applicable.

XIX. Program Integrity

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

A. Fraud, Waste and Abuse

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

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

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

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

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

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

1. Duties and responsibilities of the compliance officer and Compliance Committees.

2. How and when employees will be trained.

3. Procedures for how employee reports of non-compliance will be handled.

4. Guidelines on how the compliance department will interact with the internal audit department.

5. Guidelines on how the compliance department will interact with the legal department.

6. Guidelines on how the compliance department will interact with the Human Resources department.

7. Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.

8. Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.

9. Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.

10. Procedures for the monitoring of compliance in Contractor and subcontractor systems and processes.

11. Procedures for the monitoring of potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.

12. Procedures for performing an investigation of targets selected for audit, including triage and review processes.

13. The prohibition of any managed care entity (MCE) employee also being employed or contracted with one of their subcontractors, network providers, or providers.

b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with Contract requirements and who reports directly to the Chief Executive Officer and the Board of Directors. The Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, or any other individual operating in these roles, may not operate in the capacity of the compliance officer.

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

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

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

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

c. Maintenance of a Regulatory Compliance Committee comprised of individuals from the Board of Directors and senior management charged with overseeing the Contractor's compliance program and its compliance with requirements under the Contract.

i. Contractor must establish a Regulatory Compliance Committee that will advise the compliance officer and assists in the maintenance of the compliance program.

ii. The Compliance Officer will remain duty-bound to report on and correct alleged fraud and other misconduct.

iii. The compliance officer must chair the Regulatory Compliance Committee.

iv. The Regulatory Compliance Committee must meet no less than quarterly.

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

i. Formal Training Programs – Contractor must provide general compliance training to all employees, officers, managers, supervisors, board members and long-term temporary employees that effectively communicates the requirements of the compliance program, including the company's code of conduct and applicable Medicaid statutory, regulatory, and contractual requirements.

ii. Contractor must also determine under what circumstances it may be appropriate to train nonemployee agents and contractors.

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

iv. The initial compliance training for new employees must occur within 90 Days of the date of hire.

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

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

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

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

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

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

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

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

vi. Contractor must create an environment in which employees feel free to report concerns or incidents of wrongdoing without fear of retaliation or retribution, when making a good faith report of non-compliance.

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

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

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

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

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

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

iv. Contractor may identify a list of factors that will be considered before disciplinary action will be imposed. Such factors may include degree of intent, amount of financial harm to the company

or the government or whether the wrongdoing was a single incident or lasted over a long period of time.

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

Contractor must also conduct periodic reviews of current employees and/or subcontractors and agents to determine whether any have been suspended or debarred or are under criminal investigation or indictment. If an employee or non-employee agent or subcontractor is found to be ineligible, Contractor must have a written policy requiring the removal of the employee from direct responsibility for, or involvement with, the Medicaid program, or for the termination of the subcontract, as appropriate.

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

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

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

ii. Monitoring – Contractor must maintain a system to actively monitor compliance in all operational areas. Contractor must have a means of following up on recommendations and corrective action plans resulting from either internal compliance audit or MDHHS review to ensure timely implementation and evaluation.

Contractor must have a Questionnaire that includes questions regarding whether any exiting employee observed any violations of the compliance program, including the code of conduct, as well as any violations of applicable statutes, regulations, and Medicaid program requirements during the employee's tenure with the Contractor. The Compliance Department must review any positive responses to questions regarding compliance violations.

2. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential credible allegations of Fraud, to MDHHS-OIG. See Section 1.1.XIX.B of this Contract for the method and timing of such reporting.

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

i. Contractor must specify:

i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

ii. The process, timeframes, and documentation required for reporting the recovery of overpayments.

iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

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

b. Contractor questions regarding whether suspicions should be classified as Fraud, Waste and Abuse should be presented to MDHHS-OIG for clarification prior to making a referral.

c. Pursuant to 42 CFR438.608(a)(7), the Contractor must promptly refer any potential Fraud that the Contractor identifies.

i. Upon completion of the preliminary investigation, if the Contractor determines a potential credible allegation of fraud exists, and an

overpayment of $5,000 or greater is identified (cases under this amount shall not be referred to OIG or AG-HCFD), the Contractor must:

i. Promptly refer the matter to MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD). These referrals must be made using the MDHHS-OIG Fraud Referral Form. The template must be completed in its entirety, as well as follow the procedures and examples contained within the MDHHS-OIG guidance document.

ii. Share referral via secure File Transfer Process (sFTP) using the Contractor's applicable MDHHS-OIG/AG-HCFD sFTP areas.

iii. Cooperate in presenting the fraud referral to the OIG and AG-HCFFD at an agreed upon time and location.

iv. Defend their potential credible allegation of fraud in any appeal should the referral result in a suspension issued by MDHHS-OIG. After reporting a potential credible allegation of fraud, the Contractor shall not take any of the following actions unless otherwise instructed by OIG:

1. Contact the subject of the investigation about any matters related to the investigation;

2. Enter into or attempt to negotiate any settlement or agreement regarding the findings/overpayment; or

3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the findings/overpayment

ii. Upon making a referral, the Contractor must immediately cease all efforts to take adverse action against or collect overpayments from the referred provider until authorized by MDHHS-OIG.

iii. If a draft/potential referral is declined prior to Contractor sending a final potential credible allegation of fraud, Contractor must follow reporting procedures in Section 1.1.XIX.B of this contract.

iv. If the State successfully prosecutes and makes a recovery based on a Contractor referral where the Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor. Unless otherwise directed by the State, the correction of associated encounters is not required.

v. Contractor must refer all potential Enrollee fraud, waste or abuse that the Contractor identifies to MDHHS via the local MDHHS office or Report Fraud and Abuse (michigan.gov). In addition, the Contractor must report all fraud, waste and abuse referrals made

to MDHHS on their quarterly submission described in Section 1.1.XIX.B of this contract.

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

e. Once all applicable appeal periods have been exhausted, Contractor must adjust all associated encounter claims identified as part of their Program Integrity activities within 45 days. Failure to comply may result in a gross adjustment for the determined overpayment amount to be taken from Contractor.

   i. Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

   ii. All adjustments must be performed regardless of recovery from the Subcontractor and/or Network Provider.

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

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

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

   iii. Contractor's Network Providers must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.2et seq. and MCL 24.3 et seq. for post payment evaluations conducted by MDHHS OIG.

   iv. Section 1.1.XIX.A.2.e.i-ii requirements must be included in the Contractor's:

      i. Provider enrollment agreements, and/or:

      ii. Provider manual – if the Provider enrollment agreements require Providers to adhere to the Contractor's provider manual.

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

1. Review the Contractor's quarterly submission information to determine whether the Contractor:

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

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

2. Contact the Contractor to determine whether the Contractor and any vendors/subcontractors have identified concerns with the Provider. The Contractor must respond to MDHHS-OIG within 10 Business Days of being contacted by MDHHS- OIG.

3. After MDHHS-OIG contacts Contractor, and during pendency of MDHHS-OIG's review, Contractor must not:

    i. Initiate a new investigation on the subject of MDHHS-OIG's investigation.

    ii. Contact the subject of MDHHS-OIG's investigation about any matters related to the post payment evaluation.

4. The Contractor or its vendor/subcontractor may only initiate an investigation once they have requested and received written approval from MDHHS- OIG. Such requests will only be approved once MDHHS- OIG's investigation is closed and/or if the Contractor is investigating a separate scenario that MDHHS-OIG feels will not conflict with their investigation in any way.

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

1. Limit the scope to dates of service that are at least one year old, and:

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

vii. Determine if a claim-based audit or a sample/extrapolation post payment evaluation will be performed. If an overpayment is identified:

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

2. MDHHS will review any additional information submitted by the Provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.2 et seq. and MCL 24.3 et seq.) to both the Contractor and the Provider. The Contractor will be notified if there are any changes to MDHHS-OIG's findings after the appeal period has concluded.

3. The Contractor must not:

i. Contact the subject of MDHHS-OIG's investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding MDHHS-OIG's findings/overpayment; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with MDHHS-OIG's findings/overpayment.

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

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

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

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

withhold or offset from the next capitation payment or primary push pay to the Contractor.

ix. Contractor is responsible for the recovery of overpayments from their Providers.

x. Contractor must make all necessary adjustments (i.e., for claim-based findings) to encounter data resulting from MDHHS-OIG post payment evaluations within the encounter data correction timeliness standard outlined in the Encounter Data Submission section of this Contract (Section 3.2.II.D~~.~~). Contractor must notify MDHHS- OIG when the adjustments are complete.

1. Failure to comply with the encounter correction timeliness standard will result in Contractor incurring monetary Sanctions, as outlined in Appendix 18.

f. Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

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

a. Changes in the Enrollee's residence:

b. The death of an Enrollee.

4. Provision for notification to MDHHS-OIG when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. See Section 1.1.XIX.B of this Contract for method and timing of such reporting.

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

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

i. Contractor must respond to all MDHHS-OIG audit referrals with Contractor's initial findings report within the timeframe designated in the MDHHS-OIG referral.

Initial findings means prior to the provider receiving a final notice with appeal rights.

ii. Contractor may request a one-time extension in writing (email) to MDHHS-OIG no less than two Business Days prior to the due date, if the Contractor is unable to provide the requested

information within the designated timeframe. The request must include a status update and estimated date of completion.

iii. Unless MDHHS-OIG has granted a written extension as described above, Contractor may be subject to contract remedies including but not limited to monetary Sanctions.

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

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

1. The investigators in the unit must detect and investigate Fraud, Waste and Abuse by its Michigan Medicaid Enrollees and Providers. It must be separate from the Contractor's utilization review and quality of care functions. The unit can either be a part of the Contractor's corporate structure or operate under contract with the Contractor.

2. Contractor must have at minimum one full-time equivalent (FTE) dedicated to Michigan Medicaid for every 100,000 Michigan Medicaid Enrollees or fraction thereof.

a. While investigators may split time between multiple lines of business (or multiple states/regions) to be counted as a partial FTE, the Contractor must demonstrate that an individual dedicates a minimum of 25% of their time specifically to Michigan Medicaid in order for said individual to count towards the FTE requirement. Any individual under 25% dedication to Michigan Medicaid cannot have their work/percentage counted towards the FTE requirement.

3. On a yearly basis, the Contractor's SIU, must conduct program integrity training to improve information sharing between departments within the Contractor, such as Provider Credentialing, Payment Integrity, Customer Service, Human Resources, and the General Counsel, and to enhance referrals to the SIU regarding Fraud, Waste and Abuse within the Contractor's Medicaid program.

4. The yearly training must include a component specific to Michigan Medicaid and the Contractor's approach to address current Fraud, Waste and Abuse within the program.

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

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

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

iii. At a minimum, EOBs must be designed to address requirements found in 42 CFR 455.20 and 433.116.

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

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

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

vii. Contractor must report all EOB activities performed within the previous quarter to MDHHS-OIG. See Section 1.1.XIX.B of this Contract for the method and timing of such reporting.

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

Contractor must utilize statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices. The Contractor must report all data mining activities performed (including all program integrity cases opened as a result) within the previous quarter to MDHHS-OIG. See Section 1.1.XIX.B of this Contract for the method and timing of such reporting.

e. Preliminary Investigations – Contractor must promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste and Abuse. The Contractor must report all program integrity cases opened

within the reporting period to MDHHS-OIG. See Section 1.1.XIX.B of this Contract for the method and timing of such reporting. All confirmed or suspected provider Fraud must immediately be reported to MDHHS-OIG.

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

i. Contact the subject of the investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

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

In accordance with the Affordable Care Act, Contractor must promptly report overpayments made by Michigan Medicaid to the Contractor as well as overpayments made by the Contractor to a provider and/or Subcontractor. See Section 1.1.XIX.B of this Contract for the method and timing of such reporting.

g. Prepayment Review – If the Contractor subjects a provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to the Contractor considering it for payment, as a result of suspected Fraud, Waste and/or Abuse, the Contractor must notify MDHHS-OIG in accordance with Section 1.1.XIX.B of this Contract for the method and timing of such reporting.

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

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

7. The Contractor must have written documentation of internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected Fraud, Waste and Abuse activities.

8. Contractor must adjust all associated encounter claims identified when authorized by MDHHS-OIG for overpayment recoupment within encounter data timeliness

standard outlined in this Contract including but not limited to the Encounter Data Submission section of this Contract (Section 3.2.II.D~~.~~). Contractor failure to comply with the encounter correction timeliness standard will result in Contractor incurring monetary Sanctions as outlined in Appendix 18 and a gross adjustment for the determined overpayment amount to be taken from Contractor. In addition to the determined overpayment amount being withheld via gross adjustment, the Contractor may be subject to other contract remedies.

9. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR ~~455.23.~~ A credible allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

    a. Fraud hotline complaints;

    b. Claims data mining; or

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

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

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

B. Reporting

Contractor must send all program integrity notifications and reports to the MDHHS-OIG sFTP. The Contractor must follow the procedures and examples contained within the MDHHS-OIG submission forms and accompanying guidance document. See Appendix 19 for the listing of notification forms and reports and their respective due dates:

1. On a quarterly basis, the Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing the program integrity activities performed by the Contractor, as required by Section 1.1.XIX.A of this Contract, during the previous quarter. This report must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Contractor during the course of its program integrity activities. It is understood that identified overpayments may not be recovered during the same reporting time period. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, Contractor must:

    a. Purchase at minimum one license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the

case management system and to check the completeness and accuracy of report submissions.

b. For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid must be voided and resubmitted with zero dollars paid.

c. Specify overpayment amounts determined via sample and extrapolation, rather than claim-based review. In instances where extrapolation occurs there are no encounters to correct.

d. Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.

   i. These encounters must be identified by the Contractor and reported to MDHHS- OIG. MDHHS-OIG will record a gross adjustment to be taken out of the Contractor's next capitation payment.

e. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

   i. Contractor must adjust all associated encounters identified by MDHHS-OIG for overpayment recoupment within encounter data timeliness standard outlined in this Contract including but not limited to the Encounter Data Submission section of this Contract (Section 3.2.II.D.).

   ii. Contractor failure to comply with the encounter correction timeliness standard will result in Contractor monetary Sanction as outlined in Appendix 18, corrective action and may result in a gross adjustment for the determined overpayment amount to be taken from Contractor. In addition to the determined overpayment amount being withheld via gross adjustment, the Contractor may be subject to other contract remedies.

   iii. Contractor will not be subject to monetary Sanctions for identified encounters that are no longer available and accessible in CHAMPS.

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

3. Pursuant to 42 CFR 438.608(d)(3), on an annual basis, Contractor must submit to MDHHS- OIG, in a format determined by MDHHS-OIG, an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report also must

address the Contractor's plan of activities for the current and upcoming fiscal year. The report must include all provider and service-specific program integrity activities. The report must include an attestation confirming compliance with the requirements found in 42 CFR § 438.608 and 42 CFR § 438.610.

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

4. Any excluded individuals and entities discovered in the screening described in Section 1.1.XIX.H of this Contract, including the provider applications and credentialing documentation, must be reported to the federal HHS OIG and MDHHS-OIG, in a format determined by MDHHS-OIG, within 20 Business Days of discovery.

5. Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a Quarterly Provider Disenrollment Log for providers terminated as a result of a program integrity activity.

6. Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a Quarterly Provider Prepayment Review Placement Log for providers placed on prepayment review as a result of a program integrity activity.

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

    a. Contractor will receive a score of Met if they initiated program integrity activities as required by Section 1.1.XIX.A during the reporting period, complied with the MDHHS-OIG quarterly submission form content requirements and accompanying guidance document, and complied with deliverable due dates.

    b. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not initiated any program integrity activities, as required by Section 1.1.XIX.A of this Contract, during the previous quarter.

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

    d. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not complied with the deliverable due dates.

C. Availability of Records

Contractor must cooperate fully in any further investigation or prosecution by any duly

authorized government agency, whether administrative, civil or criminal. Such cooperation must include providing, upon request, information, access to records and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation. The Contractor must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

1. Contractor and its providers, subcontractors and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 1.1.XIX of this Contract.

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

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

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

        i. Upon request, the Contractor, its provider, or subcontractor must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the

provision of adequate space on the premises to reasonably accommodate MDHHS-OIG or other state or federal agency.

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

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

4. Contractor must maintain written policies and procedures pertaining to cooperation with any duly authorized government agency, including processes relating to the delegation of an inquiry.

D. Provider Manual and Bulletins

Contractor must issue Provider Manual and Bulletins or other means of Provider communication to the providers of medical, mental, dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all Contract requirements are being met. The Contractor may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

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

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

b. Scope of Benefits;

c. Covered Services;

d. Emergency services responsibilities;

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

f. Medical necessity standards and clinical practice guidelines;

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

i. Policies regarding provider enrollment and participation;

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

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

iv. Policies regarding record retention;

v. Policies regarding Fraud, Waste and Abuse;

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

h. Primary Care Physician responsibilities;

i. Requirements regarding background checks;

j. Other provider/subcontractors' responsibilities;

k. Prior authorization and referral procedures;

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

m. Medical records standards;

n. Payment policies;

o. Enrollee rights and responsibilities;

p. Self-reporting mechanisms and polices as cited in Section 1.1.XIX.A.2.c.

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

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

E. Provider Agreements

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

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

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

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

3. Contractor must not have a Network Provider, subcontractor, or person with an employment, consulting, or any other contractual agreement who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order.

4. Contractor must provide written disclosure of any director, officer, partner, managing employee, person with beneficial ownership of more than 5% of the Contractor's equity, Network Provider, subcontractor, or person with employment, consulting, or any other contractual agreement who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order; and any individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Act.

5. If MDHHS learns that the Contractor has a prohibited relationship as described above and provided by Federal Acquisition Regulation, Executive Order No. 12549, or under Section 1128 or 1128A of the Act, MDHHS may continue an existing agreement with the Contractor unless CMS directs otherwise. MDHHS may not renew or otherwise extend the duration of an existing agreement with the Contractor unless CMS provides to MDHHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite prohibited affiliations.

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

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

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

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

7. MDHHS may refuse to enter into or renew a contract with the Contractor if any person who has an ownership or control interest in the Contractor, or who is an Agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX Services Program. Additionally, MDHHS may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under Section 1.1.XIX.G of this Contract.

G. Disclosure by Managed Care Entities

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

1. Contractor must provide to MDHHS the following disclosures:

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

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

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

2. The disclosures must include the following:

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

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

c. Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor's employee such as a spouse, parent,

child, or siblings; or is related to one of the Contractor's officers, directors, or other owners.

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

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

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

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

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

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

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

b. When the Contractor executes the Contract with MDHHS.

c. Upon renewal or extension of the Contract.

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

e. Upon request by MDHHS.

5. All required disclosures under this subsection must be made to MDHHS, the Secretary of the US Department of Health and Human Services and the Inspector General of the US Department of Health and Human Services in the format developed by the requestor. Failure to provide required information may lead to Sanctions, including but not limited to withholding of capitation payment. Federal financial participation is not available for entities that do not comply with disclosures, therefore, MDHHS may withhold capitation from the Contractor for services provided during the period beginning on the Day following the date the information was due and ending on the Day before the date on which the information was supplied.

H. Excluded Individuals and Entities

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

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

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

3. Monetary Sanctions may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (Section 1128A(a)(6) of the Social Security Act).

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

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

I. Network Provider Medicaid Enrollment

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

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

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

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

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

XX. Contract Compliance Reviews

1. Contract compliance reviews will be conducted by MDHHS as an ongoing activity during the Contract period. Contractor's compliance review will include a desk audit and on-site focus component. The Contract compliance review will focus on specific areas of health plan performance as determined by MDHHS.

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

3. MDHHS will provide a Contract Compliance Review Timeline outlining required submissions and due dates. Contractor will receive a score of Not Met for any Contract compliance review item(s) where it has not complied with the MDHHS submission form content requirements and/or the Compliance Review Timeline Cover Page instructions. Contractor will receive a score of Not Met for any Contract compliance review item(s) where it has not complied with the deliverable due dates.

4. Contractor must utilize the MDHHS compliance monitoring system as directed by MDHHS.

A. Contract Remedies and Sanctions

1. MDHHS will utilize a variety of means to assure compliance with Contract requirements. If MDHHS determines that the Contractor fails to comply with the terms of this Contract or any other applicable laws, MDHHS may impose monetary Sanctions and other Sanctions, on the Contractor. MDHHS will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements if appropriate.

2. Monetary Sanctions imposed pursuant to this contract may be collected by deducting the amount of the monetary Sanction from any payments due to Contractor or by demanding immediate payment by Contractor. MDHHS, at its sole discretion, may establish an installment payment plan for payment of any monetary Sanction. The determination of the amount of any monetary Sanction shall be at the sole discretion of the MDHHS, within the ranges set by the MDHHS. Self- reporting by Contractor will be taken into consideration in determining the amount of any monetary Sanction. MDHHS will not impose any monetary Sanction where the non-compliance is directly caused by the MDHHS's action or failure to act or where a force majeure delays performance by Contractor.

3. MDHHS may employ Contract remedies, monetary Sanctions and other Sanctions to address any Contractor non-compliance with the Contract. Areas of non-compliance for which MDHHS may impose remedies, monetary Sanctions and other Sanctions include, but are not limited to, non-compliance with Contract requirements on the following issues:

    a. Marketing practices

    b. Member services

    c. Provision of Medically Necessary, Covered Services

    d. Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services.

    e. Provider Networks

    f. Provider payments

g. Financial requirements including but not limited to failure to comply with Physician Incentive Plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program.

h. Enrollee satisfaction

i. Healthy Behavior policy and operational process

j. Performance standards included in Appendix 4 to the Contract.

k. Misrepresentation or false information provided to MDHHS, CMS, Providers, Enrollees, or Potential Enrollees

l. URAC or NCQA Health Plan accreditation

m. NCQA Health Equity Accreditation

n. Certificate of Authority

o. Violating any of the other applicable requirements of Sections 1903(m) or 1932 of the Act and any implementing regulations

p. Community Reinvestment

4. MDHHS may utilize intermediate Sanctions (as described in 42 CFR 438 Subpart I) that may include the following:

a. Monetary Sanctions in the following specified amounts:

i. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with physician incentive plan requirements; or Marketing violations.

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

iii. A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

iv. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging copayments in excess of the amounts permitted under the Medicaid program. The State will deduct from the Sanction the amount of overcharge and return it to the affected Enrollee(s).

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

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

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

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

f. Additional Sanctions allowed under state statute or regulation that address areas of non-compliance.

g. The State will give the Contractor timely written notice for any intermediate Sanctions that specifies the basis and nature of the Sanction, in accordance with 42 CFR 438.710.

5. If intermediate Sanctions or general remedies are not successful or MDHHS determines that immediate termination of the Contract is appropriate, as allowed by Standard Contract Term provisions 15 and 24, the State may terminate the Contract with the Contractor.

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

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

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

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

6. In addition to the Sanctions described above, MDHHS may impose monetary Sanctions for repeated failure of Contractor to meet the requirements of this Contract. The determination of the amount of such Sanction shall be at the sole discretion of the MDHHS, within ranges set by MDHHS.

B. Non-Compliance

Contractor agrees and understands that MDHHS may pursue tailored contractual remedies for non-compliance with this Contract. At any time and at its discretion, MDHHS may impose or pursue one or more remedies for each item of non-compliance and will determine remedies on a case-by-case basis.

MDHHS' pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that MDHHS may be entitled to seek.

1. Notice and opportunity to cure for non-material breach: MDHHS will notify Contractor in writing of specific areas of Contractor performance that fail to meet performance expectations, standards, or requirements set forth in this Contract,

but that, in the determination of MDHHS, do not result in a material deficiency or delay in the implementation or operation of the Covered Services.

2. Contractor will receive a formal notice of identified non-compliance.

3. Contractor will, within five Business Days (or another date approved by MDHHS) of receipt of written notice of a non-material deficiency, provide the MDHHS a written response that:

    a. Explains the reasons for the deficiency.

    b. Contractor's plan to address or cure the deficiency, and

    c. The date and time by which the deficiency will be cured; or

    d. If Contractor disagrees with MDHHS' findings, its reasons for disagreeing with MDHHS' findings.

4. Contractor's proposed cure of a non-material deficiency is subject to the approval of MDHHS. Contractor's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by MDHHS as a material deficiency and entitle MDHHS to pursue any other remedy provided in the Contract or any other appropriate remedy MDHHS may be entitled to seek.

5. Notice of Non-Compliance (NONC): MDHHS may issue Notices of Non-Compliance to document small or isolated problems that the Contractor must address to comply with this Contract. Contractor is required to acknowledge receipt of the notice and respond in accordance with contract requirements listed in this section (see B.3). No enforcement action or formal Corrective Action Plan is required at the time of NONC.

6. Enforcement Action Letter: MDHHS will issue Enforcement Action Letters if the Contractor has received a NONC~~,~~ but the problem persists or for a first offence for larger or more concerning issues. Enforcement Action Letters will contain information about compliance enforcement action, including but not limited to monetary Sanctions and other Sanctions and any necessary escalation of compliance enforcement action should the non-compliance continue. Contractor is required to acknowledge receipt of the Letter and respond in accordance with the enforcement action specified in the Letter and the contract requirements listed in this section (see B.3). Receipt of an Enforcement Action Letter does not mean a formal Corrective Action Plan is required.

7. Corrective Action Plan (CAP): MDHHS may issue a CAP to correct or resolve a material deficiency, finding, event, or breach of this Contract identified by MDHHS. CAPs may be issued for a first offence for larger or more concerning issues. The Contractor must submit a complete and acceptable CAP to MDHHS within 30 Business Days from the date of receipt of MDHHS' CAP notification unless otherwise directed by MDHHS. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified material deficiency, finding, event, or breach and to develop a plan to address the findings to ensure future compliance with this Contract and state~~/~~ and federal regulations.

a. If Contractor disagrees with MDHHS' findings, Contractor must respond to MDHHS within ten Business Days of receipt of the MDHHS CAP notification including Contractor reasons for disagreeing with MDHHS' findings. This time does not toll the original CAP response due date.

8. MDHHS must approve all proposed CAPs. Contractor's CAP must include:

   a. A detailed explanation of the reasons for the cited deficiency.

   b. Contractor's assessment or diagnosis of the cause; and

   c. A specific proposal to cure or resolve the deficiency and plan to avoid future non-compliance of the deficiency.

   d. Contractor must include in its CAP milestone dates for progress and an anticipated date of resolution for the issue. Contractor must provide MDHHS with updates on the dates listed to ensure operational compliance with the CAP as proposed. The implementation of a CAP does not preclude Contractor from the accumulation of non-CAP related violations.

9. Contractor must respond to any and all inquiries and requests for further information by MDHHS. MDHHS may:

   a. Condition the approval on completion of tasks in the order or priority that MDHHS may reasonably prescribe.

   b. Disapprove portions of Contractor's proposed CAP; or

   c. Require additional or different corrective action(s).

10. MDHHS' acceptance of a CAP will not: (1) Excuse Contractor's prior substandard performance; (2) Relieve Contractor of its duty to comply with performance standards; or (3) Prohibit MDHHS from assessing additional contract remedies for substandard performance, such as monetary or other Sanctions.

11. Monetary Sanctions will be assessed as outlined below and in Appendix 18 regarding CAP submissions:

    a. Late Submission of Initial CAP: $1,000 per calendar Day for each Day a CAP submission is late.

    b. Failure to Provide Acceptable Initial CAP: $5,000 for failure to provide a complete and acceptable CAP as prescribed by MDHHS.

    c. Non-Compliance with Accepted CAP: $2, 500 per calendar Day for each Day the Contractor fails to comply with an accepted CAP as required by MDHHS.

C. Liquidated Damages and Monetary Sanctions

If the Contractor breaches this Contract, MDHHS will be entitled to monetary Sanctions in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In the

event of Contractor failure to meet specific performance standards set forth in this Contract and/or a breach of Contract where exact, associated damages cannot be determined, the Contractor will be subject to the imposition of liquidated damages or monetary Sanctions. The Contractor will be assessed liquidated damages or monetary Sanctions regardless of whether the breach is the fault of the Contractor or its subcontractors, agents and/or consultants, provided MDHHS has not materially caused or contributed to the breach. MDHHS retains the right to terminate this Contractor, either for convenience or for cause even if liquidated damages, monetary Sanctions or other Sanctions are imposed.

1. If the Contractor fails to perform any of the services described in this Contract, MDHHS may assess liquidated damages for each occurrence, as reflected in Appendix 18. Any liquidated damages assessed by MDHHS will be due and payable to MDHHS within thirty (30) Days after the Contractor's receipt of the notice of damages, regardless of any dispute in the amount or interpretation that led to the notice. MDHHS has sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.).

2. MDHHS may elect to collect liquidated damages:

    a. Through direct assessment and demand for payment delivered to the Contractor; or

    b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Contractor or that become due at any time after assessment of the liquidated damages. The Contractor will be subject to deductions until MDHHS has collected the full amount payable by the Contractor.

3. The Contractor will not pass-through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein will prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction. All liquidated damages imposed pursuant to this Contract, whether paid or due, will be paid by the Contractor out of administrative costs and profits.

4. Contractor may dispute the imposition of liquidated damages. Contractor:

    a. Must submit a written dispute of the liquidated damages directly to the MDHHS Medicaid Care Management & Customer Service Bureau Director in the manner directed by MDHHS. This submission must be received by MDHHS within 10 Business Days of Contractor receipt of notice of the imposition of liquidated damages and will include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits). Waives any dispute not raised within 10 Business Days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within 10 Business Days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Contractor's submission within the 10

Business Days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court, and any possible administrative venue).

b. Accepts the decision of the Bureau Director or his/her designee as final.

2. Personnel, Organizational Structure, Governing Body and Subcontractors

2.1 Personnel, Organizational Structure, and Governing Body

I. Personnel

The Contractor must appoint individuals who will be directly responsible for the day-to-day operations of the Contract ("Personnel"). Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 48 hours.

A. Administrative Personnel Requirements

1. Contractor must employ or contract with sufficient administrative staff to comply with all program standards. Contractor must specifically provide the following positions:

a. Executive Director/Chief Executive Officer (CEO)

b. Medical Director

c. Pharmacy Director

d. Quality Improvement Director

e. Chief Financial Officer (CFO)

f. Population Health Management Director

g. Management Information System Director

h. Compliance Officer

i. Member Services Director

j. Provider Services Director

k. Grievance and Appeals Coordinator

l. Medicaid Liaison

m. MIS Liaison

n. Privacy Officer

o. Security Officer

p. SIU Manager/Liaison

2. Contractor must ensure that all staff has appropriate training, education, experience, licensure as appropriate and liability coverage to fulfill the requirements of the positions.

3. Contractor must implement an evidence-based, comprehensive diversity, equity, and inclusion (DEI) assessment and training program for the organization. The program must assess all organizational personnel, policies, and practices. Contractor must conduct at least one implicit bias training annually as part of their DEI program and ensure that all Contractor employees who interact with Enrollees receive implicit bias training. The program must include additional facets of diversity, equity, and inclusion in addition to implicit bias.

    a. Contractor must utilize the DEI assessment and training program for the organization to develop and implement a multi-year plan for integrating diversity, equity, and inclusion into organizational policies and practices.

    b. Contractor must provide status reports on the progress of their assessment activities, including but not limited to assessment findings, training(s) conducted, evaluation results of the training, and recommended next steps based on assessment findings and training evaluation results annually as part of the Contract Compliance Review. Reports of next steps must include estimated timelines, perceived challenges/barriers, and mitigation strategies for these perceived challenges/barriers.

4. Resumes for all administrative personnel listed above in Section 2.1.I.A.1.a-p must be provided to MDHHS upon request. Resumes must include detailed, chronological work experience.

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

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

B. Executive Personnel

1. Contractor must inform MDHHS in writing within seven Days of vacancies or staffing changes for the personnel listed in Section 2.1.I.A.1.a-h of this section.

2. Contractor must inform MDHHS in writing within 14 Days of vacancies or staffing changes for the personnel listed in Section 2.1.I.A.1.i-p, except I as indicated below.

    a. For Medicaid Liaison vacancies, Contractor must inform MDHHS in writing of acting or permanent replacement within 3 Business Days of the vacancy.

3. Contractor must fill vacancies for the personnel listed in Section 2.1.I.A.1.a-h of this section with qualified persons within six months of the vacancy unless an extension is granted by MDHHS.

C. Administrative Personnel Responsibilities

1. Executive Director/Chief Executive Officer (CEO)

   a. Full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract.

   b. Oversight of budget and accounting systems.

   c. Responsibility to the governing body for daily operations.

2. Medical Director

   a. Michigan-licensed physician (MD or DO).

   b. Responsible for all major clinical program components of the Contractor.

   c. Responsibility to review medical care provided to Enrollees and medical aspects of Provider Contracts.

   d. Ensure timely medical decisions, including after-hours consultation as needed.

   e. Management of the Contractor's Quality Assessment and Performance Improvement Program (QAPI).

   f. Must ensure compliance with State and local reporting laws on communicable diseases, child Abuse, and neglect.

   g. Must coordinate with the Population Health Management Director and provide clinical leadership on population health.

3. Pharmacy Director

   a. Responsible for the performance of all pharmacy program components of the Contractor.

   b. Responsible for oversight and Contract compliance of all pharmacy program related subcontractors (i.e. Pharmacy Benefit Managers).

   c. Ensures timely pharmacy prior authorization review, processing, and claim overrides, including after-hours reviews, as warranted.

   d. Ensures compliance with Federal and State laws, regulations, and reporting requirements that are applicable to the pharmacy program.

   e. Full-time administrator who possesses the training and education necessary to meet the requirements for pharmacy director as required in the Contract. The Pharmacy Director may be any of the following:

i. Michigan licensed pharmacist.

ii. Michigan licensed certified pharmacy technician.

iii. Other licensed clinician as approved by MDHHS.

iv. Other professional possessing appropriate credentials and experience as approved by MDHHS.

4. Quality Improvement and Utilization Director

a. Full-time administrator who possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be any of the following:

i. Michigan licensed physician.

ii. Michigan licensed registered nurse.

iii. Certified professional in health care quality.

iv. Other licensed clinician as approved by MDHHS.

v. Other professional possessing appropriate credentials as approved by MDHHS.

b. Must provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed, including but not limited to:

i. Ensure the Contractor collects and meaningfully uses demographic and geographic data (e.g., race, ethnicity, language, disability, sexual orientation, gender identity) to identify disparities.

ii. Develop targeted interventions designed to reduce health disparities and address health inequities.

iii. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to reduce health disparities and address health inequities.

iv. Collaborate with the Contractor's Population Health Management Director to ensure health equity is advanced in the context of the Contractor's population health initiatives.

c. Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.

d. Contractor may provide a separate position that meets the responsibilities in Section 2.1.I.C.3.A. The position must be full-time.

5. Chief Financial Officer

    a. Full-time administrator responsible for overseeing the budget and accounting systems.

6. Population Health Management Director

    a. Master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field.

    b. Responsible for all population health management components for the Contractor.

    c. Oversee the Contractor's strategic design and implementation, of population health initiatives based on a deep understanding of scientific population health principles. Evaluation of the population health initiatives may be the responsibility of the Population Health Management Director or the Quality Improvement and Utilization Director.

    d. Sponsor and champion Contractor and system-wide initiatives, including cultivating the support necessary to achieve the desired objectives of supporting equitable whole person care for Enrollees.

    e. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals of serving the whole person, including Enrollees' medical and non-medical needs.

    f. Must coordinate with the Medical Director and the Quality Improvement and Utilization Director and external parties on population health activities.

7. Management Information System Director

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

8. Compliance Officer

    a. Full-time administrator to oversee the Contractor's compliance with the terms of this Contract, including but not limited to the Contractor's compliance plan and reporting of Fraud, Waste and Abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

9. Member Services Director

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

10. Provider Services Director

a. Coordination of communications with Subcontractors and other providers.

b. Ensure sufficient provider services staff to enable Providers to receive prompt resolution of their problems or inquiries.

11. Grievance/Appeal Coordinator

a. Coordination, management, and adjudication of Enrollee and Provider Grievances.

12. Security Officer

a. Development and implementation of security policies and procedures outlined in 45 CFR 164.

b. Designated as the individual to receive complaints pursuant to security breaches in the Contractor's or State's policies and procedures.

13. Privacy Officer

a. Development and implementation of privacy policies and procedures outlined in 45 CFR 164.

b. Designated as the individual to receive complaints pursuant to breaches of the Contractor's privacy policies and procedures.

14. Designated Liaisons

a. General management (Medicaid) liaison.

b. MIS liaison.

c. SIU manager or liaison.

15. Support/Administrative Staff

a. Contractor must have adequate clerical and support staff to ensure that the Contractor's operation functions in accordance with all Contract requirements.

II. Organizational Structure

A. Contractor Administrative Linkages

Contractor's management approach and organizational structure must ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, Grievance/Appeal review, and management information systems.

B. Contractor Administrative Practices

Contractor must be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. Contractor must employ senior level managers with experience and expertise in health care management and must employ or contract with skilled clinicians for medical management activities.

C. Contractor Organizational Chart

Contractor must provide a copy of the current organizational chart with reporting structures, names, and positions to MDHHS upon request.

D. Financial Interest for Contractor Employees

Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its Provider Network or in the conduct of the Contractor's affairs. Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes managing employees, all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

E. Disclosure of Financial Interest for Contractor Employees

1. Providers – all contracted Providers

2. Provider employees – directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity.

3. Contractor employees – director, officer, partner, managing employee, or persons with beneficial ownership of 5% or more of the entity's equity.

F. Notification of Change

Contractor must notify MDHHS in writing of a substantial change in the facts set forth in the statement within 30 Days of the date of the change. Information required to be disclosed in this section must also be available to the Department of Attorney General, Health Care Fraud Division.

G. Business Location

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

III. Governing Body

A. Contractor Governing Body

Contractor must have a governing body to ensure adoption and implementation of written policies governing the operation of the Contractor.

B. Governing Body Chair

The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body.

C. Governing Body Meetings

The governing body must meet at least quarterly and must keep a permanent record of all proceedings available to MDHHS and/or CMS upon request.

D. Governing Body Membership

1. Health maintenance organization's governing body must include no less than 1 individual who represents the health maintenance organization's membership.

2. A Health Maintenance Organization that is under a contract with this state to provide medical services authorized under subchapter XIX or XXI of the Social Security Act, 42 USC1396 to 1396 w-1 5 and 1397aa to 1397mm, must comply with either of the following requirements:

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

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

3. A health maintenance organization must meet at least quarterly unless specifically exempted from this requirement by the Director. For participation in its non-compensated Governing Body or Consumer Advisory Council, the Contractor must make good faith efforts to include and actively recruit representation that reflects:

    i. Medicaid Enrollee population in the Contractor's Service Area;

    ii. Parents/guardians of Enrollees in CSHCS;

    iii. Populations identified in Section 1.1.X.A.2.a;

    iv. Medicaid Enrollee populations who have experienced disparate perinatal outcomes; and

    v. Groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; gender identity; or geographic location).

4. The Contractor must engage the members of the non-compensated Governing Body or Consumer Advisory Council in:

    a. developing, prioritizing and evaluating policy and care strategies that promote the reduction of health disparities and advancement of health equity, and

    b. providing input on culturally appropriate service or program design.

E. Governing Body Procedures

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

1. The length of the term for board members

2. Filling of vacancies

3. Notice to Enrollees

F. Enrollee Board Members

Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan.

G. Consumer Advisory Council

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

1. How council members are chosen

2. Duties of the council members

3. The length of term for council members

4. Filling of vacancies

5. How often the council reports to the governing body and how minutes or other reports will be shared with MDHHS

6. How the council is involved in developing, prioritizing and evaluating policy and care strategies that promote the reduction of health disparities and advancement of health equity

7. How the council is involved in providing input on culturally appropriate service or program design.

2.2 Disclosure of Subcontractors

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

1. The legal business name; address; telephone number; a description of subcontractor's organization and the services it will provide; and information concerning subcontractor's ability to provide the Contract Activities.
2. The relationship of the subcontractor to the Contractor.
3. Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.
4. A complete description of the Contract Activities that will be performed or provided by the subcontractor

If the Contractor intends to change Subcontractors, the Contractor must complete Schedule K – Subcontractor Information Template and submit to the MDHHS Program Manager.

2.3 Subcontractor Requirements, Classifications and Flowdown

In addition to the requirements set forth in the Contract terms, Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to Subcontractors and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. If Contractor identifies deficiencies or areas for improvement, the Contractor and the

Subcontractor must take corrective action, including when appropriate, revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

I. Subcontractor Classifications

A. Category I: Health Benefit Managers (HBMs)

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

1. HBMs can include, but are not limited to;

   a. Pharmacy Benefit Managers,

   b. Mental Health Benefit Managers, and

   c. Vision Benefit Managers

   d. Community Health Worker Organizations

   e. Dental Benefit Managers

2. Contractor must notify MDHHS of a new Health Benefit Manager at least 30 Days prior to the effective date of the contract with the Health Benefit Manager.

3. The State reserves the right to approve or reject the Contractor's proposed use of an HBM.

B. Category II: Administrative Subcontractors

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

1. Administrative Subcontractors are classified by function.

   a. Type A Administrative Subcontractors perform administrative functions for the Contractor dealing with claims payment, Third Party Liability (TPL), or another function involving payment decisions.

   b. Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization Management, or case-management.

   c. Type C Administrative Subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical decisions. This type of administrative Subcontractor includes but is not limited to identification card production and mailing services.

2. The Contractor must notify MDHHS of any new Administrative Subcontractors at least 21 days prior to the effective date of the contract with the Administrative Subcontractor.

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

C. Category III: Transportation Subcontractor

Transportation Subcontractors are entities that arrange or arrange and provide transportation services.

1. Transportation Subcontractors are divided into two types, as follows:

   a. Type A: Transportation Benefit Managers subcontract with other entities to provide Enrollees transportation to and from health care services.

   b. Type B: Transportation Providers are entities or agencies that arrange and provide Enrollees transportation to and from health care services (e.g., social or religious agencies).

2. Contractor must notify MDHHS of Type A and Type B Transportation Subcontractors at least 30 Days prior to the effective date of the contract with the Subcontractor.

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

4. Type B Transportation Subcontractors must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract between the Contractor and Type B Transportation Subcontractor must require these Subcontractors to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage.

II. Flowdown of Contractor Responsibility

Contractor must flow-down the obligations in Section 2.3 in all of its agreements with any Subcontractors as specified by type of Subcontract.

A. Contractor Full Responsibility

1. Contractor has full responsibility for the successful performance and completion of all Contract Requirements as specified in Schedule A, regardless of whether the Contractor performs the work or subcontracts for the services.

2. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted per Section 2.2 Disclosure of Subcontractors.

3. Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract including the insurance provisions specified in the Standard Contract Terms, as applicable.

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

4. Contractor is the sole point of contact for the State with regard to all contractual matters under this Contract, including payment of any and all charges for services included in Schedule A.

B. State Consent to Delegation

Contractor must not delegate any duties under this Contract to a Subcontractor except as specified in Sections 2.2 and 2.3. MDHHS has the right of prior written approval of Health Benefit Managers and Transportation Subcontractors and to require Contractor to replace any Health Benefit Managers and Transportation Subcontractors found, in the reasonable judgment of the State, to be unacceptable.

C. Subcontractor Bound to Contract

In addition to the requirements set forth in the Contract terms, Contractor must:

1. In any Subcontracts entered into by Contractor for the performance Contractor Requirements, Contractor must require the Subcontractor, to the extent of the Contractor Requirements to be performed by the Subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State.

2. The State reserves the right to receive copies of and review all Subcontracts, although Contractor may delete or mask any proprietary information, contained in such contracts before providing them to the State, except as described in Section 1.1.VI.D.34.f. of this Contract.

3. The management of any Subcontractor is the responsibility of Contractor, and Contractor must remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not Subcontracted such performance.

4. Contractor must make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State is not obligated to direct payments for the Contractor Requirements other than to Contractor.

5. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under this Contract must not relieve Contractor of any obligations or performance required under this Contract.

6. Contractor's agreement with its Subcontractors must:

a. Require the Subcontractor comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Contract provisions.

b. Require the Subcontractor agree that the state, CMS, the DHHS Inspector General, the Comptroller General or their agents have the right to audit, evaluate, and inspect any books, records, contracts, computer or

other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the state.

c. Require the Subcontractor make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Enrollees.

d. Require the Subcontractor agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

e. Require the Subcontractor agree that if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

D. Cooperation with Third Parties

1. Contractor personnel and the personnel of any Subcontractors must cooperate with the State and its Agents and other contractors including the State's Quality Assurance personnel.

2. Contractor must provide to the State's Agents and other contractors reasonable access to Contractor's project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and will not interfere or jeopardize the safety or operation of the systems or facilities.

3. State acknowledges that Contractor's time schedule for the Contract is very specific and agrees not to unnecessarily or unreasonably interfere with, delay or otherwise impede Contractor's performance under this Contract with requests for access.

III. Subcontractor Agreements

Contractor must negotiate its agreements with its Subcontractors at arm's length without duress, coercion, or collusion, and must be negotiated as agreements between parties of equal bargaining strength.

A. Related Party Agreements

1. If Contractor negotiates an agreement with a related party, each party must act in the best interest of itself. A related party is defined as a party with a preexisting relationship or common interest including but not limited to major shareholder, affiliated provider, and entities with common ownership interests.

a. All agreements and transactions with related parties must be disclosed to MDHHS.

b. Contractor must notify and provide executed related party agreements in their entirety to MDHHS upon request. MDHHS acknowledges that such information may be considered confidential and proprietary and thus must be held strictly confidential by MDHHS as specified in the Standard Contract Terms, Section 23 – Non-Disclosure of Confidential Information of this Contract.

c. All related party agreements must be disclosed on Schedule K - Subcontractor Information Template.

d. MDHHS reserves the right to review and object to terms with any agreement between the Contractor and Subcontractor that exploits, abuses or unduly capitalizes on the Medicaid program.

3. Project Management

3.1 Meetings

I. Mandatory Administrative Meetings

A. Contractor Representatives

Contractor representative must attend the following meetings:

1. Bimonthly Administrative Issues (bimonthly)
2. Office of Medical Affairs/MHP Medical Directors (quarterly)
3. CEO (bimonthly)
4. Operations (monthly)
5. QI Directors (bimonthly)
6. Encounter Meeting (monthly)
7. MDHHS MCO Common Formulary Workgroup Meetings (quarterly)

B. Contractor Collaboration

Contractor must attend other meetings as directed by MDHHS for the purpose of performing Contract Requirements, improving workflows, and otherwise collaborating with MDHHS for benefit of Enrollees, Contractors, and the State

II. Mandatory Stakeholder Meetings

Contractor must facilitate or otherwise ensure all required meetings with entities named/described in this Contract (e.g., meetings with PIHPs, Community Collaboration meetings) take place as directed at requisite intervals.

3.2 Reporting

I. Data Reporting

A. Uniform Data and Information

1. To measure the Contractor's accomplishments in the areas of access to care, utilization, medical outcomes, Enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the Contractor must provide MDHHS with uniform data and information as specified by MDHHS.

2. Contractor must submit reports as specified in this section. Any changes in the reporting requirements will be communicated to the Contractor at least 30 Days before they are effective unless State or federal law requires otherwise.

3. Contractor must submit all reports according to Section 3.2 and provide MDHHS with additional ad hoc information as requested within the timeframes detailed in the request notification. MDHHS will make a good faith effort to ensure ad hoc requests are reasonable in scope, timing and Contractor system capabilities. Contractor failure to respond within the timeframes outlined in the request notification entitles MDHHS to pursue contract remedies, including but not limited to Sanctions, and/or liquidated damages.

4. Contractor must cooperate with MDHHS in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols.

5. Contractor must develop and implement corrective action plans to correct data validity problems as identified by MDHHS.

B. Reporting Format and Timeline

Contractor must submit reports in the format required by MDHHS and in the timeframe specified in this Contract, including but not limited to Appendix 3.

II. Contractor Reports

A. Financial Reports

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

2. Overpayment Recoveries: The Contractor must provide an annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3).

3. Contractor must submit financial reports in the format required by MDHHS and in the timeframe specified in this Contract including but not limited to Appendix 3 and Contract compliance review requirements.

4. MDHHS may require monthly financial statements from the Contractor.

5. Contractor must submit data on the basis of which MDHHS:

   a. Certifies the actuarial soundness of capitation rates to under 42 CFR 438.3, including base data described in 42 CFR 438.5(c) that is generated by Contractor.

   b. Determines the compliance of Contractor with the medical loss ratio requirement described in 42 CFR 438.8.

c. Determines that Contractor has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

6. The Contractor must submit an audited financial report specific to this Medicaid contract annually as directed by MDHHS and in accordance with 42 CFR 438.3(m).

B. Contract Compliance Review Reporting

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

1. Data Certification and Attestation Report: Contractor's CEO must submit a MDHHS Data Certification form to MDHHS that requires the Contractor to attest to the accuracy, completeness, and truthfulness of any and all data and documents submitted to the State as required by the Contract. When the health plan employs a new CEO, a new MDHHS Data Certification form must be submitted to MDHHS within 15 Days of the employment date.

2. EPSDT information: Contractor must provide the following:

a. List and brief description of member incentives offered to increase member utilization of services covered by EPSDT.

b. List and brief description of provider incentives offered to increase Provider monitoring of, reporting on, and provision of services covered by EPSDT.

3. Health Plan Profile: Contractor must provide all information requested on the Health Plan Profile form provided by MDHHS and attach all required documents.

4. Litigation Report: Contractors must submit an annual litigation report in a format established by MDHHS, providing detail for all civil litigation to which the Contractor, Subcontractor, or the Contractor's insurers or insurance Agents are party.

5. Appendix 19 Contract Compliance Review-Program Integrity requirements.

6. All documents and items specified in the MDHHS Contract Compliance Review Tool

C. HEDIS Submission

1. Contractor must annually submit a Medicaid-product HEDIS report according to the most current NCQA specifications and MDHHS timelines.

2. Contractor must contract with an NCQA certified HEDIS vendor and undergo a full audit of their HEDIS reporting process.

D. Encounter Data Submission

1. Contractor must submit to MDHHS complete and accurate Encounter Data in the form and manner described in 42 CFR 438.818 and MDHHS guidance, including but not limited to:

a. Companion Guides/Data Clarification Documents

b. Electronic File Layout Instructions

c. Encounter reporting presentations

d. Any additional MDHHS guidance made available to Contractor relating to Encounter Data submission. Encounter Data reporting requirements shall be posted to MDHHS' website:

https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_24020-150709--,00.html

2. Contractor encounter submissions must be certified by an authorized agent of the Contractor in accordance with 42 CFR 438.606.

3. Contractor must ensure that all submitted encounter data is timely, accurate and complete.

4. Within seven Days of the original submission attempt, Contractor must correct and resubmit files that fail to load in their entirety.

5. MDHHS will deem encounter data submitted when it is accepted, certified and processed in MDHHS systems.

6. Contractor must utilize National Provider Identifier (NPI) to track services and submit Encounter Data. The Contractor must submit Encounter Data containing detail for each patient encounter reflecting services provided by the Contractor.

7. When adjustments or voids are made to originally paid or denied claims, Contractor must submit these adjustments or voids appropriately so that the correct final adjudication of the claim reflects on the encounter.

8. Encounter records must be submitted monthly via electronic media in a HIPAA compliant format as specified by MDHHS.

9. Timely and complete encounter data submission must be made by the 15th of the month while meeting minimum volume requirements.

10. Encounter File transmissions must meet or exceed a 98% acceptance rate for encounters loaded into CHAMPS. The rate will be calculated monthly for each encounter type and shared with Contractor. Contractor failure to comply with the encounter acceptance rate standard may result in contract remedies including but not limited to monetary Sanctions and other Sanctions.

a. Calculation: Total number of Accepted encounter records / Total number of encounter records submitted ≥ x%

11. Annually, the Contractor will complete an Encounter Comparison Process which will compare the accepted claims/encounters in the Contractor's system to the accepted encounters in the MDHHS data warehouse by invoice type for the requested fiscal year. The universe of encounters included must include any zero-pay claims from the providers contracted under a capitated

arrangement and encounters from any subcontractors who are delegated claims processing. (This process will be considered completed when a minimum of 98% of encounters are matched, or 6 months have passed since the beginning of the process, whichever comes first). Contractor failure to achieve a percentage of 98% or greater for each calculation, may be subject to contract remedies including but not limited to monetary Sanctions and other Sanctions.

E. Matching Percentage Calculations

There are two calculations used to check for the matching percentage.

i. Contractor ERN on list with match in MDHHS data warehouse

ii. Calculation: Total number of matched ERN encounter records by invoice type / Total number of submitted ERN encounter records submitted by invoice type ≥ x%

iii. MDHHS data warehouse ERN with match on Contractor ERN list

iv. Calculation: Total number of matched ERN encounter records by invoice type / Total number of ERN encounter records accepted in the data warehouse by invoice type ≥x%

1. Contractor must populate all fields required by MDHHS including but not limited to, financial data for all encounters and fields required for the MCO pharmacy rebate. Submitted Encounter Data will be subject to quality data edits prior to acceptance into MDHHS's data warehouse. The Contractor's data must pass all required data quality edits in order to be accepted into MDHHS's data warehouse. Any data that is not accepted into the MDHHS data warehouse will not be used in any analysis, including but not limited to rate calculations, DRG calculations, and risk score calculations. MDHHS will not allow Contractors to submit incomplete Encounter Data for inclusion into the MDHHS data warehouse and subsequent calculations.

2. Contractor will be held responsible for errors or non-compliance resulting from their own actions or the actions of an agent authorized to act on their behalf. Subcontracted encounter data must comply with all MDHHS requirements and specifications.

3. Stored Encounter Data will be subject to regular and ongoing quality checks as developed by MDHHS. MDHHS will give the Contractor a minimum of 60 Days' notice prior to the implementation of new quality data edits; however, MDHHS may implement informational edits without 60 Days' notice. The Contractor's submission of Encounter Data must meet timeliness and completeness requirements as specified by MDHHS. The Contractor must participate in regular data quality assessments conducted as a component of ongoing Encounter Data on- site activity.

4. Contractor must review and respond in accordance with MDHHS guidance to MDHHS encounter submission responses including but not limited to rejected and/or denied encounter files and records. Contractor must review the CHAMPS

Encounter Transaction Results Report and reconcile the errors listed in the report.

5. Contractor must make all necessary adjustments to encounter data resulting from MDHHS reviews including but not limited to quality, accuracy, program integrity and validation checks. All adjustments must be completed and resubmitted to MDHHS in accordance with the Encounter correction timeliness standard established by MDHHS. Contractor must notify MDHHS when the adjustments are resubmitted.

Number of Transaction Control Numbers (TCNs) to be Corrected and/or Resubmitted (Does not include any corresponding voids for resubmissions)	**Number of Days After the Request is Made by MDHHS** **That Those Encounters Must Be Submitted to and Accepted by CHAMPS**
5,000 or less	45 Days
Greater than 5,000	60 Days

6. Failure of the Contractor to submit encounter data and resubmissions in accordance with MDHHS timeliness standard may result in contract remedies including but not limited to monetary Sanction and other Sanctions in accordance with contract standards.

7. MDHHS may consider approval of extended timeframes for encounter data submission and resubmission on a case-by-case basis per the Contractor's written request which must include an extenuating reason for such a request and estimated date of completion.

    a. Written requests for an extension must be received by MDHHS no less than two Business Days, prior to the due date outlined in the MDHHS encounter submission timeliness standard. Any extension request not received by the extension request due date stated in this paragraph, will be denied.

    b. Excessive extension requests will be considered Contractor noncompliant performance and MDHHS may pursue contract remedies including but not limited to monetary Sanction and other Sanctions in accordance with contract standards.

F. Encounter Data Quality Standards

1. MDHHS will review for and validate all submitted encounter data for completeness and accuracy.

2. Contractor must fully cooperate with all MDHHS efforts to monitor Contractor's compliance with the requirements of encounter submission. Contractor must comply with all requests related to encounter data monitoring in a timely manner as directed by MDHHS.

3. Contractor must submit encounter data for enrollee health services that the Contractor incurred a financial liability and must include encounters for services provided that were eligible to be processed but where no financial liability was incurred by the Contractor.

4. MDHHS or its designee may investigate encounter data quality issues including but not limited to:

    a. Utilization

    b. Service date lag time benchmarks

    c. Expected EDI fail amounts

    d. Average paid amount per service, by billing code

    e. Application of National Correct Coding Initiatives edits

    f. Compliance with benefit and processing rules detailed in the Michigan Medicaid Provider manual, as appropriate, and

    g. Payment for duplicate services

5. Contractor must collect and maintain all encounter data for each covered service and supplemental benefit services provided to Enrollees, including encounter data from any sub-capitated sources.

6. Contractor must evaluate the completeness and quality of its subcontractor encounter data and keep record of its procedures and evaluations. Records must be made available upon MDHHS request.

7. Contractor must participate in site visits and other reviews and assessments conducted by MDHHS or its designee, for the purpose of evaluating Contractor's collection, submission, and maintenance of encounter data.

8. Contractor must cooperate and comply with any audit arranged for by MDHHS to determine accuracy, truthfulness, and completeness of submitted encounter data.

9. Contractor must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MDHHS' data quality standards.

10. Contractor must participate in MDHHS' Encounter Quality Initiative. Contractor must:

    a. Attend and participate in all MDHHS scheduled monthly quality phone meetings. Submit timely completed EQI data template requests and Appendices, in accordance with the Encounter Quality Initiative Schedule.

    b. Submit timely completed EQI reconciliation comparison report in accordance with the Encounter Quality Initiative Schedule.

c. Acquire and maintain access to any required software applications or tool needed to complete the EQI reconciliation report.

11. Contractor failure to participate in MDHHS encounter quality reviews in accordance with MDHHS standards may entitle MDHHS to pursue contract remedies including but not limited to monetary Sanction and other Sanctions.

G. Claims Reporting

1. Contractor must provide to MDHHS monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by MDHHS.

H. Quarterly Grievance and Appeal Report

1. Contractor must track the number and type of Grievances and Appeals.

2. Appeals information must be summarized by the level at which the Grievance or Appeal was resolved and reported in the format designated by MDHHS.

3. Contractor must utilize the definition of Grievance and Appeal specified in this Contract for tracking and reporting Grievance and Appeals.

I. Healthy Michigan Plan Reporting

Contractor must comply with all the reporting requirements specified in the following:

1. P.A. 98 of 2023

2. MDHHS Policy and Operational Process

J. Provider Race/Ethnicity/Language Reporting

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

K. Data Submission

The Contractor must submit to the State the following data:

1. Documentation described in 42 CFR 438.207(b) on which MDHHS bases its certification that Contractor has complied with MDHHS' requirements for availability and accessibility of services, including the adequacy of the Provider Network, as set forth in 42 CFR 438.206.

2. Information on ownership and control described in 42 CFR 455.104 of as governed by 42 CFR 438.230.

L. Other Program Integrity Reports

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

M. Other Data Sources

MDHHS may develop other data sources and/or measures during the course of the Contract term. MDHHS will work with the Contractor to develop data formats and mechanisms for

data submission. The Contractor must work with MDHHS to provide data in the format and timeline specified by MDHHS.

III. Release of Report Data

A. Written Approval

Contractor must obtain MDHHS's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its Enrollees other than as required by this Contract, statute or regulations. The State is the owner of all data made available by the State to the Contractor or its Agents, Subcontractors or representatives under the Contract.

B. Acceptable Use of State Data

In addition to the requirements set forth in the Contract terms, Contractor will not use the State's data for any purpose other than providing the Services to Enrollees covered by the Contractor under any Contract or Program, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data.

C. Acceptable Use of Personally Identifiable Data

1. In addition to the requirements set forth in the Contract terms, Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services to Enrollees covered by the Contractor under any Contract or Program and must disclose the information only to its employees on a strict need-to-know basis.

2. In addition to the requirements set forth in the Contract terms, including Schedule E, Data Security, Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

D. Acceptable Use of Contractor Data

In addition to the requirements of the Contract terms, The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees on a strict need to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

4. Payment and Taxes

4.1 Payment Terms

I. General

A. Full Risk

Contracts are full risk.

B. State Directed Payments

Contractor must fully participate with all State Directed Payments approved by CMS. These State Directed Payments may require Contractors to implement specific payment parameters such as amount, frequency, and provider. The parameters the State establishes with Contractors will be generated based on selection criteria and performance monitoring that has been approved by CMS. State Directed Payments will be incorporated into Contractor rates. State Directed Payments may require Contractors to pay hospitals, specialty providers, or PCPs with the goal of ensuring access and high-quality care for Medicaid Enrollees. Contractors must follow payment instructions provided by MDHHS separate from this Contract.

II. Payment Provisions

A. Fixed Price

Payment under this Contract will consist of a fixed reimbursement plan with specific monthly payments based upon a unit price of a Per-Member Per-Month (PMPM) Capitated Rate. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. Capitation payments may only be made by MDHHS and retained by the Contractor for Medicaid-eligible enrollees.

B. Maternity Case Rate

MDHHS will pay a maternity case rate payment to the Contractor for Enrollees who give birth while enrolled in the Contractor's plan, except that MDHHS will not pay a Maternity Case Rate for Enrollees who are dually eligible for Medicare and Medicaid. The Contractor must submit a valid encounter that supports the maternity case rate payment; the encounter must meet all encounter standards and be accepted by MDHHS within 6 months of the birth. Services that support a maternity case rate are specified in Appendix 6. If MDHHS does not have an accepted encounter from the Contractor within 6 months from the birth, MDHHS will recoup the Maternity Case Rate payment. After the recoupment, the Contractor has 6 months to submit an accepted encounter and request a manual re-payment of the maternity case rate. If the Contractor does not submit an accepted encounter within 6 months after the recoupment, the recoupment will be considered final and a maternity case rate payment will not be paid for the birth.

C. Capitation Rates

1. MDHHS will establish actuarially sound capitation rates developed in accordance with the federal requirements for actuarial soundness. The accepted definition of Actuarial soundness is: Medicaid Capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government mandated assessments, fees, and taxes imposed by this state and

the federal government including the Health Insurer fee that the Contractor incurs and becomes obligated to pay under Section 9010 of the Patient Protection and Affordable Care Act, Public Law111-148, as amended by the Health Care and Education Reconciliation Act of 2010, due to its receipt of Medicaid premiums pursuant to the contract. For purposes of this subsection, the full cost of the Health Insurer Fee includes both the Health Insurer Fee and the allowance to reflect the federal and state income tax. The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent capitation rate development methodology that incorporates relevant information which may include:

a. The annual financial filings of all Contractors.

b. Relevant Medicaid FFS data.

c. Relevant Contractor Encounter Data.

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

3. MDHHS will establish State Directed Payments (SDP) in accordance with 42 CFR 438.6 and include SDP with rate certifications outlined in Appendix 22. Contractor must adhere to the provisions of SDP as outlined in those arrangements.

D. Risk Adjustment

The price per covered member will be risk adjusted (i.e., it will vary for different categories of Enrollees). For Enrollees in the Blind and Disabled, Temporary Assistance for Needy Families and Healthy Michigan Plan program categories, Michigan will utilize the Chronic Illness and Disability Payment System (CDPS) or another comparable risk adjustment methodology to adjust the capitation rates paid to the Contractor. Under CDPS, diagnosis coding as reported on claim and encounter transactions are used to compute a score for each Enrollee. Enrollees with inadequate eligibility history will be excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case mix value for each Contractor based on its enrolled population.

E. Regional Rate

The regional rate for the Aging, Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each Contractor. The aggregate impact will be budget or rate neutral. MDHHS will fully re-base the risk adjustment system annually. A limited adjustment to the case mix adjusted rates will occur in the intervening six-month intervals based only on Contractor enrollment shifts.

F. Annual Review

MDHHS will annually review changes in implemented Medicaid Policy to determine the financial impact on the CHCP. Medicaid Policy changes reviewed under this section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in Covered Services, and modifications to Medicaid rates for Covered Services. If MDHHS determines that the policy changes significantly affect the overall cost to the CHCP,

MDHHS will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

G. Enrollment Files

MDHHS will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, MDHHS will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and MDHHS will report payments to Contractors on a HIPAA-compliant 820 file. A process will be in place to ensure timely payments and to identify Enrollees the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns). MDHHS may initiate a process to recoup Capitation Payments made to the Contractor for Enrollees who were retroactively disenrolled or who are granted retroactive Medicare coverage.

H. Contract Remedies and Performance Bonus Payments

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

1. The State may deduct from whatever is owed Contractor on this Contract an amount sufficient to compensate the State for any damage resulting from termination or rescission.

2. Any payment to Contractor may be reduced or suspended when a provision of this Contract requires a payment or refund to the State or an adjustment of a payment to the Contractor.

3. The State may deduct from whatever is owed to the Contractor of this Contract an amount equal to the Sanctions and/or liquidated damages levied against Contractor.

4. If any failure of the Contractor to meet any requirement of this Contract results in the withholding of federal funds from the State, the State may withhold and retain an equivalent amount from payments to Contractor until such federal funds are released, in whole or in part, to the State, at which time the State will release to Contractor an amount equivalent to the amount of federal funds received by the State.

I. Activities No Longer Authorized by Law

1. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment

for that work should be returned to the state. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

III. Medical Loss Ratio (MLR)

A. Contractor is subject to a minimum MLR of 85 percent. The MLR calculation in a reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8((e)) to the denominator (as defined in accordance with 42 CFR 438. ((f)). A Minimum Utilization Requirement is the MLR calculation excluding State Directed Payments. The MLR and Minimum Utilization Requirement provisions apply on a contract-specific basis and include revenue and expense experience applicable to Enrollees included under the Contract.

B. Contractor must submit to MDHHS a consolidated MLR and Minimum Utilization Requirement report for its Medicaid population for each MLR reporting year, as directed by MDHHS and in accordance with 42 CFR 438.8. Contractor must use the reporting tool provided by MDHHS for MLR and Minimum Utilization Requirement reporting requirements for each fiscal reporting year of the Contract. Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR and Minimum Utilization Requirement reports.

C. Failure of Contractor to meet the minimum MLR will result in remittance of funds from Contractor. MDHHS will also require remittance of additional funds to the extent the Minimum Utilization Requirement exceeds the minimum MLR. Within 90 Days of MDHHS' notice to Contractor of its remittance requirement, Contractor must remit back to MDHHS a rebate consistent with the MLR and Minimum Utilization Requirement reporting tool. Rebates paid to MDHHS will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care Program.

D. Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR and Minimum Utilization Requirement reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of the MLR and Minimum Utilization Requirement reporting.

E. In any instance where MDHHS makes a retroactive change to the capitation payments for a reporting year where the MLR and Minimum Utilization Requirement reports have already been submitted to the state, the Contractor must:

    1. Recalculate the MLR and Minimum Utilization Requirement for all reporting years affected by the change.

    2. Submit a new MLR and Minimum Utilization Requirement report meeting the applicable State and Federal requirements.

IV. Dental Claim Loss Ratio

A. Contractor is subject to a Dental Claim Loss Ratio of 80 percent, as described in this Contract. The established MDHHS Dental Claim Loss Ratio measures dental costs incurred by Contractor to the dental benefit expense included in the capitation rate paid to Contractor and involves minimum dental utilization assumptions. The Dental Claim Loss Ratio utilizes a

composite that is included in the State of Michigan Medicaid Rate Certification Letter to CMS and projects average per-member utilization of dental services for the fiscal year.

The numerator of the Dental Claim Loss Ratio is the number of accepted encounter lines with one or more dental units (multiplied by 12,000) with paid amount greater than $0. The denominator of the Dental Claim Loss Ratio is the number of member months.

B. MDHHS will calculate the Dental Claim Loss Ratio using Contractor encounter data for dental services incurred for the period beginning October 1, 2024, through September 30, 2025, with a six (6)-month claims run-off allowance.

C. Failure of Contractor to meet the minimum Dental Claim Loss Ratio will result in remittance of funds from Contractor. Within 90 Days of MDHHS' notice to Contractor of its failure to meet the minimum Dental Claim Loss Ratio, Contractor must remit back to MDHHS a rebate involving the difference between the incurred dental benefit expense and the benefit expense included in the dental capitation rate paid to Contractor.

If Contractor meets the Dental Claim Loss Ratio of 80 percent, no rebate is collected. If Contractor meets the Dental Claim Loss Ratio of 70 percent, MDHHS will recover a rebate in the amount equal to 50 percent of the difference between the incurred dental benefit expense and the benefit expense included in the dental capitation rate paid to Contractor. If Contractor fails to meet the Dental Claim Loss Ratio of 70 percent, MDHHS will recover a rebate in the amount equal to 100 percent of the difference between the incurred dental benefit expense and the benefit expense included in the dental capitation rate paid to Contractor.

V. Contractor Performance Bonus

A. Performance Bonus (Quality Withhold)

In accordance with MDHHS' commitment to quality improvement, innovation, and operational excellence, MDHHS will withhold a percentage of the capitation payment from Contractor and make the return of these withheld funds contingent upon Contractor meeting certain quality and performance metrics.

For fiscal year 2025, MDHHS will withhold 2.00% of the capitation payment. MDHHS reserves the right to revise the withhold percentage ahead of each fiscal period. Withheld funds will be used for the Contractor performance bonus awards, specified in Appendix 5, and support program initiatives as part of the MDHHS quality strategy. Awards will be made to Contractor according to criteria established by MDHHS (see Appendix 5) and in compliance with 42 CFR 438.6(b). Contractor's performance will be measured during the rating period in which the withhold arrangement is applied.

B. Criteria for Performance Bonus (Quality Withhold)

The criteria for awards include but are not limited to assessment of performance in quality of care, access to care, Enrollee satisfaction, and certain administrative functions, as described in Appendix 5. Each year, MDHHS will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

VI. Community Reinvestment

A. Contractor must contribute a minimum of five (5) percent of its annual pre-tax profits to community reinvestment demonstrating its commitment to the local communities in which it

operates. Profit, for the purposes of the Community Reinvestment policy, represents MHP reported revenues in excess of reported plan program expenditures as identified through MDHHS reporting. MDHHS reporting will reflect the Medical Loss Ratio Template modified to include non-benefit expenses for purposes of calculating profits to be used in identifying any Community Reinvestment obligation. As such, profit includes underwriting gains considering both benefit and non-benefit expenses. Contractor's community reinvestment or any community investment above the annual minimum must be funded through pre-tax profits and not divert from medical or administrative expenses. MDHHS reserves the right to increase the community reinvestment contribution percentage in future years of the Contract.

B. The Contractor must expend its community reinvestment obligation during the investment period specified by MDHHS in Appendix 12. Contractor is not permitted to expend funds outside the designated investment period.

C. Contractor's community reinvestment obligation must be used to address HRSN.

    1. A minimum of 60% of the total community reinvestment obligation must be invested in activities that address food insecurity. The remaining amount can support activities that address food insecurity or housing instability.

    2. The Contractor is encouraged to fund activities that support the ability of CBOs to offer nutrition ILOS and to work with other Contractors in or near their Service Area to maximize the collective impact of community reinvestment activities.

D. Contractor must not use community reinvestment funding to pay for services covered under the Contract or ILOS, or to fulfill other contractual requirements.

E. Contractor's community reinvestment obligation be invested in CBOs and must not include entities in which the Contractor has a full or partial ownership stake or any financial interest.

F. Contractor must submit an annual initial estimate of its community reinvestment obligation in accordance with timeliness requirements specified in Appendix 3 and additional requirements specified in Appendix 12.

G. Contractor must submit an annual Community Reinvestment Spending Plan detailing its anticipated community reinvestment activities for MDHHS review and approval, in accordance with timeliness requirements specified in Appendix 3 and additional requirements specified in Appendix 12MDHHS will provide Contractor with a template for this Community Reinvestment Spending Plan.

H. Contractor must submit an annual Community Reinvestment Expenditures Report detailing Contractor's actual community reinvestment expenditures, including to what extent these investments supported CBOs engaged in the delivery of ILOS, in accordance with timeliness requirements specified in Appendix 3 and additional requirements specified in Appendix 12. MDHHS will provide Contractor with a template for the Community Reinvestment Expenditures Report.

I. Contractor must engage community partners or coalitions in each of the Regions they are contracted to serve in the development of the Community Reinvestment Spending Plan as specified in Appendix 12. Contractor must also present a summary of its Community Reinvestment Expenditures Report to community partners or coalitions.

J. Contractor must comply with all other community reinvestment requirements outlined in Appendix 12.

K. If the Contractor fails to comply with the requirements outlined in this section and in Appendix 12, MDHHS may pursue contractual remedies as described in Section 1.1.XX and Appendix 18.

4.2 Taxes

I. Tax Excluded from Price

A. Sales and Use Tax:

Generally, the State is exempt from sales and use tax for direct purchases. Contractor's prices must not include sales or use tax unless a specific exception applies.

B. Use Tax

Specific Exception: MCL 205.93f sets out a specific exception to the State's general use tax exemption. This exception applies to contracts for purchase of medical services beginning April 1, 2014, from entities identified in MCL 400.106(2)(a) and MCL 400.109f involving certain Medicaid contracted health plans and some specialty prepaid health plans. Purchases of services that fall under these provisions are subject to use tax.

C. Federal Excise Tax

The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles are purchased under any resulting Contract for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax.

II. Employment Taxes

The Contractor must collect and pay all applicable federal, State, and local employment taxes, including the taxes.

III. Sales and Use Taxes

A. Contractor Remittance of Sale Tax

Contractor is required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors lacking sufficient presence in Michigan to be required to register and pay taxes must do so voluntarily. This requirement extends to:

1. All members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member.

2. All organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes.

B. Organization Definition

In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in

§701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

5. Health Insurance Portability and Accountability Act (HIPAA)

5.1 HIPAA Business Associate Agreement Addendum

At the time of Contract execution, the Contractor (“Business Associate”) must sign and return a Health Insurance Portability and (HIPAA) Business Associate Agreement Addendum (Appendix 10) to the individual specified in the Standard Contract Terms (2) of the Contract. The Business Associate performs certain services for the State (“Covered Entity”) under the Contract that requires the exchange of information including protected health information under the HIPAA of 1996, as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5). The HIPAA Business Associate Agreement Addendum establishes the responsibilities of both parties regarding HIPAA-covered information and ensures the underlying contract complies with HIPAA.

DEFINITIONS

Term	Definition
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)
The Act	The Social Security Act
Advance Directive	A written legal instruction, such as a living will, personal directive, advance decision, durable power of attorney or health care proxy, where a person specifies what actions should be taken relating to the provision of health care when the individual is incapacitated.
Adverse Benefit Determination	An action or inaction by the Contractor including any of the following: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner, as defined by the MDHHS. 5. The failure of the Contractor to act within the timeframes provided in §438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals. 6. For a Rural Area Resident with only one MCO, the denial of an Enrollee's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network. The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.
Advisory Committee on Immunization Practices (ACIP)	A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
Agent (of the entity)	Any person who has express or implied authority to obligate or act on behalf of the State, Contractor, Subcontractor, or Network Provider.
Alternative Formats	Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats must include, but not be limited to, Braille,

	large font, audio tape, video tape, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.
Alternative Payment Models (APM)	A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. At times, the term APM is used interchangeably with Value-Based Payment (VBP).
Alternative Payment Model "Numerators"	**Big Numerator:** Total dollars paid to providers through payment reforms in Categories 2C-4 in payment period divided by total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period. **Small Numerator:** Total dollars paid to (and/or collected from) providers under Category 2C-4 APMs during payment period divided by total dollars paid to providers (in and out of network) for Medicaid beneficiaries during payment period.
Appeal	Review by the Contractor of an Adverse Benefit Determination.
Beneficiary	Any person determined eligible for the Michigan Medical Assistance Program.
Billing Issue	Any situation in which a beneficiary has received a bill for services that they believe should have been covered by Medicaid.
Bundled Payments or Episode of Care Models	A type of value-based payment model that takes into consideration the quality, costs, and outcomes for a patient-centered course of care over a set period of time and across multiple settings.
Business Continuity and Disaster Recovery Plan (BC-DR)	A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation, and procedures in the event that the primary processing site is lost to the Managed Care Plan.
Business Day	Monday through Friday, 8:00 AM through 5:00 PM EST (unless otherwise stated) not including State or federal holidays.
Capitated Rate	A fixed per person monthly rate payable to the Contractor by MDHHS for provision of all Covered Services defined within this Contract.
Capitation Payment (see Capitated Rate)	A payee receives a specified amount per patient to deliver services over a set period of time. Usually the payment is determined on a per member/per month (PMPM) basis.
Care Coordination	Organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Patients' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.
Care Management	A team-based, patient-centered approach designed to assist Enrollees and their caregivers in managing medical, social and mental health conditions effectively.

Case Management	Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. “Targeted” case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.
Centers for Medicare and Medicaid Services (CMS)	The federal agency (and its designated agents) within the United States’ Department of Health and Human Services responsible for federal oversight of the Medicaid, Medicare, and the Children’s Health Insurance Program.
Child Care Institution	A child care facility which is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year.
Children in Foster Care	Children in Foster Care are those placed outside the child’s parental home by and under the supervision of a child placing agency, the court, or the department, up to the child’s 18th birthday, or 19th birthday for youth committed to the Michigan Children’s Institute (MCL 400.203), or a youth who participates in Young Adult Voluntary Foster Care up to their 21st birthday. Children in Foster Care do not include children for whom there has been a delegation of a parent’s or guardian’s powers regarding care, custody, or property of a child or ward under a properly executed power of attorney under the safe families for children act.
Children’s Special Health Care Services (CSHCS)	CSHCS is a program within MDHHS for eligible children and some adults with special health care needs and their families. CSHCS is authorized under Title V of the Social Security Act. CSHCS program eligibility criteria is available at General Information for Families About Children's Special Health Care Services. Individuals eligible for both CSHCS and Medicaid are mandatorily enrolled into an MHP.
Clean Claim	All claims as defined in 42 CFR § 447.45 and MCL 400.111i.
Clinical Advisory Committee (CAC)	Clinical Advisory Committee appointed by MDHHS.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
Collaboration	A process of working with others to achieve shared goals.
Community Collaboration Project	A plan for developing policies and defining actions to improve Population Health.
Community Health Needs Assessment (CHNA)	A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community’s health needs and identified issues.
Community Health Representatives (CHR)	Frontline public health workers who improve access to healthcare in American Indian and Alaskan Native (AI/AN) communities and build community capacity.

Community Health Workers (CHWs) or Peer-Support Specialists	Frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
Community Mental Health Services Programs (CMHSP)	Community Mental Health Services Programs (CMHSPs) and the organizations with which they contract provide a comprehensive range of services and supports to children, adolescents and adults with mental illnesses, developmental disabilities and substance use disorders in all 83 Michigan counties.
Community Reinvestment Obligation	Five percent of annual pre-tax profits that MHPs are required to reinvest in the local communities they serve.
Community-Based Health	A strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities by coordinating Population Health improvement strategies.
Community-based Organization (CBO)	Public and private non-profit organizations that represent a community or significant segments of a community and provide educational, health, social support or other related services to individuals in the community. They include organizations providing, for example, nutrition, housing and non-medical transportation services; coordination of long-term services and supports; and/or support for those experiencing interpersonal violence. Trusted by the communities they serve, CBOs have deep relationships, knowledge of the local environment and critical expertise in the delivery of social care.
Complaint	A communication (oral or written) by a Beneficiary or a Beneficiary's representative to MDHHS or the Contractor expressing a concern about the care or service provided by the Contractor or their Subcontractors.
Contract	A binding agreement entered into by the State of Michigan and the Contractor.
Contractor	Successful Bidder who was awarded a Contract. In this Contract, the terms Contractor, HMO, Contractor's plan, Medicaid Health Plan, MHP and health plan are used interchangeably.
Covered Services	All services provided under Medicaid, as defined in the Contract that the Contractor has agreed to provide or arrange to be provided to Enrollees.
Counties with Extreme Access Considerations (CEAC)	Unless otherwise indicated in this Contract, Counties with Extreme Access Considerations (or CEAC) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.

Culturally and Linguistically Appropriate Services (CLAS)	Health Care goal to reduce Health Disparities and to provide optimal care to patients regardless of their race, ethnic background, native languages spoken, and religious or cultural beliefs.
Customer Assessment of Healthcare Providers and Systems (CAHPS®)	The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a set of survey tools developed to assess patient satisfaction with their health plan.
Days	Calendar days unless otherwise specified.
Deliverables	Physical goods and/or commodities as required or identified under the Contractor Requirements.
Department of Insurance and Financial Services (DIFS)	Responsible for oversight of insurers, Health Maintenance Organizations (HMOs), and financial entities doing business in the State.
Diagnosis Related Group (DRG)	Defined in the Medicaid Institutional Provider Chapter as hospital payments including applicable outliers and capital costs at the per-discharge rate.
Disaster Recovery Plan	A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation, and procedures in the event that the primary processing site is lost to the Managed Care Plan.
Durable Medical Equipment (DME)	Medical equipment and supplies provided by specialized providers and/or pharmacies which may require prior authorizations.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Benefits defined in Sections 1902(a)(43) and 1905(r) of the Act and 42 CFR 441.50 including: Medically Necessary comprehensive and preventive health care services provided to Enrollees under the age of 21, such as screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and mental health conditions discovered by the screening services, whether or not such services are covered under the state plan. Medically Necessary services are determined on a case-by-case basis (see Medical Necessity or Medically Necessary).
Electronic Funds Transfer (EFT)	Ability to electronically exchange funds between entities.
Electronic Health Record (EHR)	Ability to electronically exchange eligibility and claim information with Providers.
Electronic Visit Verification (EVV)	The electronic verification and documentation of visit data, such as the date and time the Provider begins and ends the delivery of services, the identity of the attendant and recipient, and the location of services provided.
Emergency Dental Services	Care for an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.
Emergency Intervention Services	Emergency services needed to evaluate or stabilize an emergency medical condition furnished by a provider certified as qualified by

	MDHHS. Emergency Intervention Services are provided to a person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship that requires immediate intervention as defined by the person or the person's family or social unit. These services include Tier 1 Mobile Crisis, Tier 2 Community Crisis Response, Mental Health Urgent Care, and Crisis Support Unit services, and are covered as described in Appendix 7.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, for a pregnant Enrollee the health of the Enrollee or unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.
Emergency Services	Covered inpatient and outpatient services, including Mental Health Services, that are furnished to an Enrollee by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.
Encounter Data	Medical records containing detail for each enrollee encounter with a Provider for health services for which Contractor paid Providers for Covered Services.
Enrollee	Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in the Contractor's Medicaid Health Plan.
Enrollment Capacity	The number of Enrollees or Potential Enrollees that the Contractor can serve through its Provider Network under a Contract with the State. Enrollment Capacity is determined by MDHHS in consultation with Contractor based upon its Provider Network organizational capacity, available risk-based capital, and Contractor's ability to meet Network adequacy and access to care standards and requirements of this Contract.
Enrollment Services Contractor	An entity contracted with MDHHS to contact and educate general Medicaid beneficiaries about managed care and to assist beneficiaries to enroll, disenroll, and change enrollment with their Contractor.
Expedited Appeal	An Appeal conducted when the Contractor determines (based on the Enrollee request) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Contractor decision must be made within 72 hours of receipt of an Expedited Appeal.
Expedited Authorization Decision	An authorization decision required to be expedited due to a request by the Provider or determination by the Contractor that following the standard timeframe could seriously jeopardize the Enrollee's life or health. Contractor's decision must be made in three working days from the date of receipt.

Experimental/ Investigational	Drugs, biological agents, procedures, devices, or equipment determined by the Behavioral and Physical Health and Aging Services Administration, that have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used.
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
Explanation of Benefits (EOB)	Statement to covered individuals explaining the medical care or services that were paid for on their behalf.
External Quality Review (EQR)	EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health services that an MCP or its contractors furnish to Medicaid beneficiaries [see 42 C.F.R. § 438.320]. EQR can only be conducted by a qualified External Quality Review Organization (EQRO). Must be included as part of the Contractor's written plan for the Quality Assessment and Performance Improvement Plan (QAPI). Performance improvement goals, objectives and activities which are part of the Contractor's written plan for the Quality Assessment and Performance Improvement Program (QAPI).
External Quality Review Organization (EQRO)	An EQRO is an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs the EQR, EQR-related activities, or both. Agency that provides EQR data analysis and assessment.
Family Team	A child's Family Team can include parents, extended family members, friends, children (if age appropriate), community members, foster parents, school staff, caregivers and child welfare staff who are committed to assisting a family in creating and reviewing a plan related to the child's safety, stability, well-being and permanence. Team members are primarily identified by the family/youth to support them throughout their case and beyond
Federally Qualified Health Center (FQHC)	Community-based organizations that provide comprehensive health care services to persons of all ages, regardless of their ability to pay or health insurance status with no authorization required.
Fee-for-service (FFS)	A reimbursement methodology that provides a payment amount for each individual service delivered.
File Transfer Service (FTS)	A secure electronic location for files to be transferred between MDHHS, Contractors and their Agents.
Financial Independence Program (FIP)	Medicaid eligible group mandatorily enrolled in the CHCP.
Fiscal Agent	An entity that manages fiscal matters on behalf of another party.
Food Insecurity	Being unable to obtain nutritionally adequate, medically appropriate, and/or safe foods.
Former Foster Care Youth	Former Foster Care Youth are those individuals who have Foster Care Transitional Medicaid (FCTMA) in CHAMPS
Foster Care Transitional Medicaid (FCTMA)	As defined in Michigan's Children's Foster Care Manual, "Foster Care Transitional Medicaid" or FCTMA is available to youth who are under age 26 *and* at the time of the youth's 18th birthday, was under the responsibility of MDHHS or a Tribal court *and* in an out-

	of-home placement (including absent without legal permission, or AWOLP). A youth who aged out of foster care in another State before moving to Michigan before age 26 would also qualify for FCTMA. There is no income eligibility requirement.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law (42 CFR § 455.2).
Freedom of Information Act (FOIA)	Allows access by the general public to data held by national governments.
Grievance	Grievance means an expression of dissatisfaction about any matter other than an action subject to Appeal. (42 CFR 438.400) Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.
Habilitative Services and Devices	Service or device that helps a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Benefit Manager (HBM)	Any entity that arranges for the provision of health services covered, excluding transportation, under a written contract or agreement with the Contractor.
Health Care Payment Learning & Action Network (LAN)	A public-private partnership dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.
Health Care Transition (HCT)	The process of moving from a child/family-centered health care model to an adult/patient-centered model of health care, starting prior to the age of 14 and continuing into young adulthood. The goals of HCT are a) to improve the ability of youth and young adults to manage their own health and effectively use health services; (b) to ensure a planned process for HCT.
Health Disparities	A particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).
Health Equity	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal

	health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
Health Equity Advisory Team (HEAT)	An Advisory Team convened by the LAN to identify and prioritize opportunities to advance health equity through APMs, to influence design principles and to inform LAN priorities and initiatives.
Health Insurance Portability and Accountability Act (HIPAA)	The protection of medical records and information ensuring any individual's information is secure and only shared with others through their consent.
Health Maintenance Organization (HMO)	An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 500.3501.
Health Related Social Needs (HRSN)	Health Related Social Needs, as defined by CMS, are an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying Social Determinants of Health.
Healthcare Effectiveness Data and Information Set (HEDIS®)	The result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a widely used set of performance measures that provides some objective information with which to evaluate health plans and hold them accountable.
Healthy Michigan Plan (HMP)	Approved CMS Program to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.
In Lieu of Services (ILOS)	ILOS are medically appropriate and cost-effective services or settings that are substitutes for services or settings covered under the state plan. CMS formally recognized states' and managed care plans' abilities to cover ILOS through the finalization of 42 CFR § 438.3(e)(2). Enrollees and managed care plans are not required to use or offer ILOS, respectively.
Indian Health Care Provider (IHCP)	A healthcare program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization (otherwise known as I/T/U as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
Indian Health Services/Tribal Health Centers/Urban Indian Organizations (I/T/U)	Health care providers specifically for American Indian/Alaska Native.
Inflationary Payments	Inflationary payments refer to any agreement a PBM may have with a manufacturer where the manufacturer agrees to a payment back to the PBM if a drug has inflation above an agreed upon level.
Initial Appointment	The first scheduled examination by Provider for a new patient admitted into the practice.
Initial Enrollment	First enrollment in Medicaid Health Plan following determination of eligibility; re-enrollment in a Medicaid Health Plan following a gap in

	eligibility of less than two months is not considered Initial Enrollment.
Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)	Care facilities specifically for persons with Intellectual Disabilities.
Investment Period	The period in which the Contractor must invest their community reinvestment obligation.
Large Metropolitan ("Large Metro")	Unless otherwise indicated in this Contract, Large Metropolitan (or Large Metro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.
Limited Capitation (Payment) Models	Under partial or blended capitation models, only certain types or categories of services are paid on a capitated basis.
List of Excluded Individuals/Entities (LEIE)	List of Excluded Individuals/Entities. List of people/entities who have been debarred or otherwise excluded under the Federal Acquisition Regulations and are not allowed to be in the Contractor's Provider Network.
Marketing	In the Contractor's approved Service Area they may promote their services to the general population of an entire city, county or larger population segment in the community.
Marketing Materials	Contractor must seek MDHHS' approval of materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.
Michigan Compiled Laws (MCL)	The official codification of statutes for the State of Michigan.
Michigan Department of Licensing and Regulatory Affairs (LARA)	The Michigan Department of Licensing and Regulatory Affairs (LARA) oversees health profession licensing.
Medicaid	A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.
Medicaid Health Plan (MHP)	Managed care organizations that provide or arrange for the delivery of comprehensive health care services to Medicaid Enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as a Health Maintenance Organization (HMO). See also Contractor.
Medical Assistance Program	The Michigan Medicaid program authorized under Title XIX of the Social Security Act.
Medical Eligibility Referral Form (MERF)	Documentation to determine medical eligibility for the CSHCS program.

Medical Necessity or Medically Necessary	For Enrollees 21 years of age and older, Covered Services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. For Enrollees less than 21 years of age, a service that meets the EPSDT standard of Medical Necessity set forth in Section 1905(r) of the Act and 42 USC Section 13®(r)(5). Without limitation, Medically Necessary services for Enrollees less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development; attain, regain, or maintain functional capacity; or improve, support, or maintain the Enrollee's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medicare Exclusion Database (MED)	Maintains the list of individuals and businesses that have been excluded from participating in the Medicare Program during the period of exclusion.
Metropolitan ("Metro")	Unless otherwise indicated in this Contract, Metropolitan (or Metro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.
Michigan Care Improvement Registry (MCIR)	The Michigan Care Improvement Registry (MCIR) is an immunization database that documents immunizations given to individuals receiving immunization care in Michigan.
Micropolitan ("Micro")	Unless otherwise indicated in this Contract, Micropolitan (or Micro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.
Mild-to-Moderate	Individuals determined as having Mild-to-Moderate mental health needs include: (1) child and adolescent Enrollees without Serious Emotional Disturbance (SED) or whose severity has not yet been diagnosed; and (2) adult Enrollees without Serious Mental Illness (SMI) or whose severity has not yet been diagnosed.
National Association of Insurance Commissioners (NAIC)	The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

National Committee for Quality Assurance (NCQA)	The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations.
National Plan and Provider Enumeration System (NPPES)	NPPES is a database administered by the Centers for Medicare and Medicaid Services (CMS) to "improve the efficiency and effectiveness of the electronic transmission of health information" by standardizing the format of unique identification for healthcare providers and health plans.
National Provider Identifier (NPI)	A unique 10-digit identification number issued to health care providers in the United States by CMS.
Non-Urgent Symptomatic Care	An Enrollee encounter with a Provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention.
Out-of-Network	Covered Services rendered to an Enrollee by a provider that is not part of Contractor's Provider Network.
Overpayment	The amount paid by the Medicaid agency or its Contractors to a provider which is in excess of the amount that is allowable for services furnished.
Patient-Centered Medical Home (PCMH)	The PCMH model combines the essence of primary care with innovations to better align care processes with patient needs. The core principles include improved access, continuity of care, comprehensive team-based care, care coordination, quality and safety, and a reimbursement structure that supports the functions of primary care. A key component of the model is that everyone, both adults and children, maintains an ongoing relationship with a team at the practice level, led by a personal primary care clinician that collectively takes responsibility for ongoing care.
Peer-Support Specialists	Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.
Per Member Per Month (PMPM)	Capitated unit price payments to contracted primary care.
Persons with Special Health Care Needs (PSHCN)	Enrollees who have lost eligibility for the CSHCS program due to the program's age requirements.
PIHP Network Provider	An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with a PIHP or any PIHP subcontractor, for the delivery of services covered by the PIHP.
Population Health	Management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the oral and physical health and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.

Post-stabilization Care Services	Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, to improve of resolve the Enrollee's condition.
Potential Enrollee	Medicaid Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an Enrollee in the Contractor's MHP.
Prepaid Inpatient Health Plan (PIHP)	A plan that contracts with MDHHS to provide specialty services and supports related to mental health, substance use disorder, and intellectual and/or developmental disability, as described in Appendix 7.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
Preventative Services (Dental)	Preventive dental services include services such as oral evaluations, routine cleanings, x-rays, sealants, and fluoride treatments.
Primary Care Provider (PCP)	Providers designated by the Enrollee and/or Contractor as responsible for providing or arranging health care services for the Enrollee. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician, nurse practitioner, physician assistant, or other physician specialist as appropriate based on the Enrollee's health condition.
Profit	For the purposes of the Community Reinvestment policy, represents MHP reported revenues in excess of reported plan program expenditures as identified through MDHHS reporting. MDHHS reporting will reflect the Medical Loss Ratio Template modified to include non-benefit expenses for the purposes of calculating profits to be used in identifying any Community Reinvestment obligation. As such, profit includes underwriting gains considering both benefit and non-benefit expenses.
Provider (or Network Provider)	An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any subcontractor, for the delivery of Covered Services to Enrollees.
Provider Contract	A written agreement between the Contractor and a Provider for the provision of services under the Contract.
Provider Network	The collective group of Network Providers who have entered into Provider Contracts with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to, physical, mental health, pharmacy, and ancillary service providers.
Quality Assessment and Performance Improvement Program (QAPI)	An ongoing program for the services furnished to the Contractor's Enrollees that meets the requirements of 42 CFR 438.240. Quality Assurance and Performance Improvement (QAPI) is a data driven and proactive approach to quality improvement. It combines two approaches - Quality Assurance (QA) and Performance Improvement (PI). QA is a process used to ensure services are meeting quality standards and assuring care reaches a certain level.
Quality Improvement Committee (QIC)	The QIC reviews the Contractor QAPI program, its results and activities, and recommends changes on an ongoing basis.

Rebates	Rebates include manufacturer fees and administration fees for rebating
Recoupment	Any formal action by the State or its contractors to initiate recovery of an overpayment made to a Provider.
Region	Groupings of contiguous counties defined and numbered as follows: 1. Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft 2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford 3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon 4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newago, Oceana, Osceola, Ottawa 5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw 6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola 7. Clinton, Eaton, Ingham 8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren 9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw 10. Macomb, Oakland, Wayne
Routine Care (Dental)	Dental services that include the diagnosis and treatment of oral health conditions to prevent deterioration to a more severe level or minimize/reduce the risk of development of dental disease or the need for more complex dental treatment. Examples include but are not limited to services such as fillings and space maintainers.
Routine Care (Medical)	An Enrollee encounter with a Provider that is not associated with any presenting medical signs. Examples include well-child visits and annual adult physical examinations.
Rural Area Resident	A Medicaid beneficiary who resides in a county for which the State has federal approval to limit choice of MHP to a single MHP, per 42 CFR 438.52(b)(1). Applicable counties are listed in Appendix 1 of this Contract.
Rural County	Unless otherwise indicated in this Contract, a Rural County refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget."
Rural Health Clinic (RHC)	Public, non-profit, or for-profit healthcare facility located in rural medically underserved area. In Michigan, RHCs are certified by LARA to participate in Medicare and Medicaid programs under an agreement with CMS. The current RHCs in Michigan are listed at the following website: Federal – Rural Health Clinics (michigan.gov)
Sanction	An action taken by MDHHS against Contractor to hold Contractor accountable for failure to comply with the terms of this Contract or

	any applicable laws or regulations. Sanctions can include but are not limited to liquidated damages and other actions described in 42 CFR 438 Subpart I.
Serious Emotional Disturbance (SED)	Per Mental Health Code, a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) A substance use disorder. (b) A developmental disorder. (c) "V" codes in the Diagnostic and Statistical Manual of Mental Disorders.
Serious Mental Illness	Per Mental Health Code, a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance. Serious mental illness does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness: (a) A substance use disorder. (b) A developmental disorder. (c) A "V" code in the Diagnostic and Statistical Manual of Mental Disorders.
Service Authorization Decision	Contractor's written response to Enrollee's service authorization request provided as expeditiously as the Enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following the receipt of the request for service, with a possible extension of up to 14 additional calendar days if---(i) The Enrollee, or the Provider requests an extension; or (ii) Contractor justifies a need for additional information and how the extension is in the Enrollee's best interest.
Service Authorization Request	A managed care Enrollee's request for the provision of a service.
Sexually Transmitted Infection (STI)	Serious infections that can be screened for and may be treated with early identification.
Social Determinants of Health (SDOH), also	The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities.

referred to as Social Drivers of Health	These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social Determinants of Health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.
Social Services	Social Services directly address Social Needs, including Health Related Social Needs. These services are often delivered in the community and include things like food and nutrition supports, housing and non-medical transportation services (not inclusive of emergency and non-emergency medical transportation [NEMT]).
State	The State of Michigan, including any departments, divisions, agencies, offices, commissions, officers, employees, and agents.
State Directed Payments	State directed payments are required under 42 C.F.R. § 438.6(c)(2)(ii)(B) to direct expenditures equally, using the same terms of performance, for a class of providers providing the service under the contract.
State Fair Hearing	An impartial review by MDHHS of a decision made by the Contractor that the Enrollee believes is inappropriate.
Subcontractor	An individual or entity that has a contract with an MHP that relates directly or indirectly to the performance of the MHP's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MHP.
Substance Use Disorder (SUD)	Per Mental Health Code, a chronic disorder in which repeated use of alcohol, drugs, or both, results in significant and adverse consequences. Substance use disorder includes substance abuse.
System for Award Management (SAM)	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. SAM.gov
Temporary Assistance to Needy Families (TANF)	The Temporary Assistance for Needy Families (TANF) program provides grant funds to states and territories to provide families with financial assistance and related support services. State-administered programs may include childcare assistance, job preparation, and work assistance.
Third Party Liability (TPL)	Other health insurance plan or carrier.
United States Code (USC)	Federal regulations
Urgent Care (Dental)	Services required to prevent serious deterioration of oral health following the onset of an unforeseen condition or injury.
Urgent Care (Medical)	Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Utilization Management (UM)	Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called “utilization review.”
Vaccines For Children Program (VFC)	A federal program which makes vaccine available free to immunize children aged 18 and under who are Medicaid eligible.
Value-Based Payment (VBP)	See “Alternative Payment Models (APM)”
Waste	The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.
Women Infants and Children (WIC)	Women, Infants, and Children (WIC) is a federally funded Special Supplemental Nutrition Program of the Food and Nutrition Service of the United States Department of Agriculture and is administered by the Michigan Department of Health and Human Services, serving low and moderate income pregnant, breastfeeding, and postpartum women, infants, and children up to age five who are found to be at nutritional risk.

6. 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. All services and products provided as a result of this Contract must comply with all applicable State IT policies and standards.

Public IT Policies, Standards and Procedures (PSP):

DTMB - IT Policies, Standards & Procedures (michigan.gov)

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 1340.00.130.02 Acceptable Use of Information Technology (michigan.gov). 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.

ADA Compliance for Enrollee and Provider Website(s) or Web Portal(s)

The State is required to comply with the Americans with Disabilities Act of 1990 (ADA) and has adopted standards and procedures regarding accessibility requirements for websites and software applications. All websites, applications, software, and associated content and documentation provided by the Contractor as part

of the Solution must comply with Level AA of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0.

7. End-User Operating Environment for Enrollee and Provider Website(s) or Web Portal(s)

The SOM environment is X86 VMware, IBM Power VM, MS Azure/Hyper-V and Oracle VM, with supporting platforms, enterprise storage, monitoring and management.

Contractor must accommodate the latest browser versions (including mobile browsers) as well as some pre-existing browsers. To ensure that users with older browsers are still able to access online services, applications must, at a minimum, display and function correctly in standards-compliant browsers and the state standard browser without the use of special plugins or extensions. The rules used to base the minimum browser requirements include:

- Over 2% of site traffic, measured using Sessions or Visitors (or)
- The current browser identified and approved as the State of Michigan standard

This information can be found at https://www.michigan.gov/browserstats. Please use the most recent calendar quarter to determine browser statistics. Support is required for desktop and mobile and tablet browsers identified with over 2% of site traffic.

Contractor must support the current and future State standard environment at no additional cost to the State.

8. Enrollee and Provider Website(s) or Web Portal(s)

Contractor must provide Enrollee and Provider Website(s) or Web Portal(s)

9. Migration

Contractor responsible for migration if Contractor switches Hosting Provider.

Enter company name here

SCHEDULE B - RESERVED

Enter company name here

SCHEDULE C – INSURANCE REQUIREMENTS

Contract No.

1. **General Requirements.** Contractor, at its sole expense, must maintain the insurance coverage as specified herein for the duration of the Term. Minimum limits may be satisfied by any combination of primary liability, umbrella or excess liability, and self-insurance coverage. To the extent damages are covered by any required insurance, Contractor waives all rights against the State for such damages. Failure to maintain required insurance does not limit this waiver.
2. **Qualification of Insurers.** Except for self-insured coverage, all policies must be written by an insurer with an A.M. Best rating of A- VII or higher unless otherwise approved by DTMB Enterprise Risk Management.
3. **Primary and Non-Contributory Coverage.** All policies for which the State of Michigan is required to be named as an additional insured must be on a primary and non-contributory basis.
4. **Claims-Made Coverage.** If any required policies provide claims-made coverage, Contractor must:

a. Maintain coverage and provide evidence of coverage for at least 3 years after the later of the expiration or termination of the Contract or the completion of all its duties under the Contract;

b. Purchase extended reporting coverage for a minimum of 3 years after completion of work if coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the Effective Date of this Contract.

5. **Proof of Insurance.**

a. Insurance certificates showing evidence of coverage as required herein must be submitted to DTMB-RiskManagement@michigan.gov within 10 days of the contract execution date.

b. Renewal insurance certificates must be provided on annual basis or as otherwise commensurate with the effective dates of coverage for any insurance required herein.

c. Insurance certificates must be in the form of a standard ACORD Insurance Certificate unless otherwise approved by DTMB Enterprise Risk Management.

d. All insurance certificates must clearly identify the Contract Number (e.g., notated under the Description of Operations on an ACORD form).

e. The State may require additional proofs of insurance or solvency, including but not limited to policy declarations, policy endorsements, policy schedules, self-insured certification/authorization, and balance sheets.

f. In the event any required coverage is cancelled or not renewed, Contractor must provide written notice to DTMB Enterprise Risk Management no later than 5 business days following such cancellation or nonrenewal.

6. **Subcontractors.** Contractor is responsible for ensuring its subcontractors carry and maintain insurance coverage.
7. **Limits of Coverage & Specific Endorsements.**

a. Contractor Insurance Coverage.

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: **$1,000,000 Each Occurrence** **$1,000,000 Personal & Advertising Injury** **$2,000,000 General Aggregate**	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 20 10 12 19 and CG 20 37 12 19. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
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: **$10,000,000 Each Occurrence** **$10,000,000 Annual Aggregate**	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime (Fidelity) Insurance	
Minimum Limits: **$2,000,000 Employee Theft Per Loss**	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.

Required Limits	Additional Requirements
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: **$5,000,000 Each Occurrence** **$5,000,000 Annual Aggregate**	

8. **Non-Waiver.** This Schedule C 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.

SCHEDULE D – RESERVED

SCHEDULE E – DATA SECURITY REQUIREMENTS FOR HYBRID PURCHASES

1. Definitions. For purposes of this Schedule, the following terms have the meanings set forth below. All initial capitalized terms in this Schedule that are not defined in this **Schedule** shall have the respective meanings given to them in the Contract.

"**Contractor Security Officer**" has the meaning set forth in **Section 2** of this Schedule.

"**FedRAMP**" means the Federal Risk and Authorization Management Program, which is a federally approved risk management program that provides a standardized approach for assessing and monitoring the security of cloud products and services.

"**FISMA**" means The Federal Information Security Modernization Act of 2014 (Pub.L. No. 113-283 (Dec. 18, 2014.).

"Hosting Provider" means any subcontractor that is providing any or all of the Hosted Services under this Contract.

"Hosted Services" means the hosting of State Data, management and operation of the operating environment, software, other services (including support and subcontracted services), and related resources for access and use by Enrollees or Providers, as defined in the Statement of Work, including any services and facilities related to disaster recovery obligations. Hosted Services includes, but is not limited to, Management Information Systems and the use of Health Information Exchange or Health Information Technology, as set forth in Schedule A, Statement of Work.

"**NIST**" means the National Institute of Standards and Technology.

"**PCI**" means the Payment Card Industry.

"Process" means to perform any operation or set of operations on any data, information, material, work, expression or other content, including to (a) collect, receive, input, upload, download, record, reproduce, store, organize, combine, log, catalog, cross-reference, manage, maintain, copy, adapt, alter, translate or make other improvements or derivative works, (b) process, retrieve, output, consult, use, disseminate, transmit, submit, post, transfer, disclose or otherwise provide or make available, or (c) block, erase or destroy. **"Processing"** and **"Processed"** have correlative meanings.

"**PSP**" or **"PSPs"** means the State's IT Policies, Standards and Procedures.

"**SSAE**" means Statement on Standards for Attestation Engagements.

2. Security Officer. Contractor will appoint a Contractor employee to respond to the State's inquiries regarding the security of the Hosted Services who has sufficient knowledge of the security of the Hosted Services and the authority to act on behalf of Contractor in matters pertaining thereto ("**Contractor Security Officer**").

3. Contractor Responsibilities. 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 any State Data in Contractor's or its subcontractor's possession; and

(e) ensure that all Contractor Representatives comply with the foregoing.

The State has established Information Technology (IT) PSPs to protect IT resources under the authority outlined in the overarching State 1305.00 Enterprise IT Policy. 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 public and non-public State IT policies and standards, of which the publicly available ones are at DTMB - IT Policies, Standards & Procedures (michigan.gov).

This responsibility also extends to all service providers and subcontractors with access to State Data or an ability to impact the contracted solution. Contractor responsibilities are determined from the PSPs based on the services being provided to the State, the type of IT solution, and the applicable laws and regulations.

4. **Acceptable Use Policy.** To the extent that Contractor has access to the State's IT environment, Contractor must comply with the State's Acceptable Use Policy, see 1340.00.130.02 Acceptable Use of Information Technology (michigan.gov). All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing State systems. The State reserves the right to terminate Contractor's and/or subcontractor(s) or any Contractor Personnel's access to State systems if the State determines a violation has occurred.

5. **Protection of State's Information.** Throughout the Term and at all times in connection with its actual or required performance of the Contract Activities, Contractor will:

5.1 If Hosted Services are provided by a Hosting Provider, ensure each Hosting Provider maintains FedRAMP authorization for all Hosted Services environments throughout the Term, and in the event a Hosting Provider is unable to maintain FedRAMP authorization, the State, at its sole discretion, may either a) require the Contractor to move the Software and State Data to an alternative Hosting Provider selected and approved by the State at Contractor's sole cost and expense without any increase in Fees, or b) immediately terminate this Contract for cause pursuant to **Section 25** of the Contract;

5.2 for Hosted Services provided by the Contractor, maintain either a FedRAMP authorization or an annual SSAE 18 SOC 2 Type II audit based on State required NIST Special Publication 800-53 MOD Controls using identified controls and minimum values as established in applicable State PSPs.

5.3 ensure that the Software and State Data is securely stored, hosted, supported, administered, accessed, developed, and backed up in the continental United States, and the data center(s) in which the data resides minimally meet Uptime Institute Tier 3 standards (www.uptimeinstitute.com), or its equivalent;

5.4 maintain and enforce an information security program including safety and physical and technical security policies and procedures with respect to its Processing of the State Data that complies with the requirements of the State's data security policies as set forth in this Contract, and must, at a minimum, remain compliant with FISMA and NIST Special Publication 800-53 MOD Controls using identified controls and minimum values as established in applicable State PSPs;

5.5 provide technical and organizational safeguards against accidental, unlawful or unauthorized access to or use, destruction, loss, alteration, disclosure, encryption, transfer, commingling or processing of such

information that ensure a level of security appropriate to the risks presented by the processing of State Data and the nature of such State Data, consistent with best industry practice and applicable standards (including, but not limited to, compliance with FISMA, NIST, CMS, IRS, FBI, SSA, HIPAA, FERPA and PCI requirements as applicable);

5.6 take all reasonable measures to:

(a) secure and defend all locations, equipment, systems and other materials and facilities employed in connection with the Contract Activities against "malicious actors" and others who may seek, without authorization, to destroy, disrupt, damage, encrypt, modify, copy, access or otherwise use Hosted Services or the information found therein; and

(b) prevent (i) the State from having access to the data of other customers or such other customer's users of the Contract Activities; (ii) State Data from being commingled with or contaminated by the data of other customers or their users of the Contract Activities; and (iii) unauthorized access to any of the State Data;

5.7 ensure that State Data is encrypted in transit and at rest using FIPS validated AES encryption modules and a key size of 128 bits or higher;

5.8 ensure the Hosted Services support Identity Federation/Single Sign-on (SSO) capabilities using Security Assertion Markup Language (SAML), Open Authentication (OAuth) or comparable State approved mechanisms;

5.9 ensure the Hosted Services implements NIST compliant multi-factor authentication for privileged/administrative and other identified access.

6. Reserved.

7. Reserved.

8. Security Audits.

8.1 During the Term, Contractor will maintain complete and accurate records of its data protection practices, IT security controls, and the security logs relating to State Data, including but not limited to any backup, disaster recovery or other policies, practices or procedures relating to the State Data and any other information relevant to its compliance with this Contract.

8.2 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. 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. If the State chooses to perform an on-site audit, Contractor will, make all such records, appropriate personnel and relevant materials available during normal business hours for inspection and audit by the State or an independent data security expert that is reasonably acceptable to Contractor, provided that the State: (i) gives Contractor at least five (5) Business Days prior notice of any such audit; (ii) undertakes such audit no more than once per calendar year, except for good cause shown; and (iii) conducts or causes to be conducted such audit in a manner designed to minimize disruption of Contractor's normal

business operations and that complies with the terms and conditions of all data confidentiality, ownership, privacy, security and restricted use provisions of the Contract. The State may, but is not obligated to, perform such security audits, which shall, at the State's option and request, include penetration and security tests, of any and all Hosted Services and their housing facilities and operating environments.

8.3 During the Term, Contractor will, when requested by the State, provide a copy of Contractor's and Hosting Provider's FedRAMP System Security Plan(s) or SOC 2 Type 2 report(s) to the State within two weeks of the State's request. The System Security Plan and SSAE audit reports will be recognized as Contractor's Confidential Information.

8.4 With respect to State Data, Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

8.5 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 8.**

9. Application Scanning. During the Term, Contractor must, at its sole cost and expense, scan all Contractor provided applications, and must analyze, remediate and validate all vulnerabilities identified by the scans as required by the State Secure Web Application and other applicable PSPs.

Contractor's application scanning and remediation must include each of the following types of scans and activities:

9.1 Dynamic Application Security Testing (DAST) – Scanning interactive application for vulnerabilities, analysis, remediation, and validation (may include Interactive Application Security Testing (IAST).

(a) Contractor must either a) grant the State the right to dynamically scan a deployed version of the Software; or b) in lieu of the State performing the scan, Contractor must dynamically scan a deployed version of the Software using a State approved application scanning tool, and provide the State with a vulnerabilities assessment after Contractor has completed such scan. These scans and assessments i) must be completed and provided to the State quarterly (dates to be provided by the State) and for each major release; and ii) scans must be completed in a non-production environment with verifiable matching source code and supporting infrastructure configurations or the actual production environment.

9.2 Static Application Security Testing (SAST) - Scanning source code for vulnerabilities, analysis, remediation, and validation.

(a) For Contractor provided applications, Contractor, at its sole expense, must provide resources to complete static application source code scanning, including the analysis, remediation and validation of vulnerabilities identified by application source code scans. These scans must be completed for all source code initially, for all updated source code, and for all source code for each major release and Contractor must provide the State with a vulnerability assessment after Contractor has completed the required scans.

9.3 Software Composition Analysis (SCA) – Third Party and/or Open Source Scanning for vulnerabilities, analysis, remediation, and validation.

(a) For Software that includes third party and open source software, all included third party and open source software must be documented and the source supplier must be monitored by the Contractor for notification of identified vulnerabilities and remediation. SCA scans may be included as part of SAST and DAST scanning or employ the use of an SCA tool to meet the scanning requirements. These scans must be completed for all third party and open source software initially, for all updated third party and open source software, and for all third party and open source software in each major release and Contractor must provide the State with a vulnerability assessment after Contractor has completed the required scans if not provided as part of SAST and/or DAST reporting.

9.4 In addition, application scanning and remediation may include the following types of scans and activities if required by regulatory or industry requirements, data classification or otherwise identified by the State.

(a) If provided as part of the solution, all native mobile application software must meet these scanning requirements including any interaction with an application programing interface (API).

(b) Penetration Testing – Simulated attack on the application and infrastructure to identify security weaknesses.

10. Infrastructure Scanning.

10.1 For Hosted Services, Contractor must ensure the infrastructure and applications are scanned using an approved scanning tool (Qualys, Tenable, or other PCI Approved Vulnerability Scanning Tool) at least monthly and provide the scan's assessments to the State in a format that is specified by the State and used to track the remediation. Contractor will ensure the remediation of issues identified in the scan according to the remediation time requirements documented in the State's PSPs.

11. Nonexclusive Remedy for Security Breach. Any failure of the Contract Activities to meet the requirements of this Schedule with respect to the security of any State Data or other Confidential Information of the State, including any related backup, disaster recovery or other policies, practices or procedures, is a material breach of the Contract for which the State, at its option, may terminate the Contract immediately upon written notice to Contractor without any notice or cure period, and Contractor must promptly reimburse to the State any Fees prepaid by the State prorated to the date of such termination.

SCHEDULE F – RESERVED

SCHEDULE G- RESERVED

SCHEDULE H- RESERVED

SCHEDULE I- RESERVED

SCHEDULE J – ORGANIZATIONAL CHART

The Contractor must provide an overall organizational chart that details staff members, by name and title/position, including reporting structures and subcontractors.

SCHEDULE K- SUBCONTRACTOR INFORMATION

This will be maintained outside of Contract document.

Category I: Health Benefit Manager	For more than 1 subcontractor per category duplicate page(s)
Full Name of Subcontractor	
Related Party? Yes/No	
Is the Subcontractor a Geographically Disadvantaged Business Enterprise (GDBE)	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
Does Contractor have a previous working relationship with the Subcontractor? If yes, provide the details of that previous relationship.	
Description of Subcontractor's Organization	
Description of Work to be Subcontracted	
Information concerning Subcontractor's ability to provide the Contract activities	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
If GDBE, percentage of work to be done	
If GDBE, the total amount estimated to be paid to the GDBE	
If GDBE, was evidence provided for their qualification as being GDBE? Yes/No	

Category II: Administrative A, B or C	For more than 1 subcontractor per category duplicate page(s)
Full Name of Subcontractor	
Related Party? Yes/No	
Is the Subcontractor a Geographically Disadvantaged Business Enterprise (GDBE)	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
Does Contractor have a previous working relationship with the Subcontractor? If yes, provide the details of that previous relationship.	
Indicate Administrative A, B, or C	
Description of Subcontractor's Organization	
Description of Work to be Subcontracted	
Information concerning Subcontractor's ability to provide the Contract activities	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
If GDBE, percentage of work to be done	
If GDBE, the total amount estimated to be paid to the GDBE	
If GDBE, was evidence provided for their qualification as being GDBE? Yes/No	

Category III: Transportation	For more than 1 subcontractor per category duplicate page(s)
Full Name of Subcontractor	
Related Party? Yes/No	
Is the Subcontractor a Geographically Disadvantaged Business Enterprise (GDBE)	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
Does Contractor have a previous working relationship with the Subcontractor? If yes, provide the details of that previous relationship.	
Indicate Transportation Type A or B	
Description of Subcontractor's Organization	
Description of Work to be Subcontracted	
Information concerning Subcontractor's ability to provide the Contract activities	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
If GDBE, percentage of work to be done	
If GDBE, the total amount estimated to be paid to the GDBE	
If GDBE, was evidence provided for their qualification as being GDBE? Yes/No	

APPENDIX 1: EXCEPTION FOR RURAL AREA RESIDENTS

The State has received federal approval to implement an exception for Rural Area Residents in the following Michigan counties, allowing MDHHS to limit the choice of Rural Area Residents to a single managed care organization.

At this time, only the 15 counties in the Upper Peninsula operate under this exception.

Upper Peninsula	Lower Peninsula
Alger	Alcona
Baraga	Allegan
Chippewa	Alpena
Delta	Antrim
Dickinson	Arenac
Gogebic	Barry
Houghton	Benzie
Iron	Branch
Keweenaw	Charlevoix
Luce	Cheboygan
Mackinac	Clare
Marquette	Crawford
Menominee	Emmet
Ontonagon	Gladwin
Schoolcraft	Grand Traverse
	Gratiot
	Hillsdale
	Huron
	Ionia
	Iosco
	Isabella
	Kalkaska
	Lake
	Leelanau
	Lenawee
	Manistee
	Mason
	Mecosta
	Missaukee
	Montcalm
	Montmorency
	Newaygo
	Oceana
	Ogemaw
	Osceola
	Oscoda
	Otsego
	Presque Isle
	Roscommon
	St. Joseph
	Sanilac
	Tuscola
	Van Buren
	Wexford

APPENDIX 2: MDHHS FINANCIAL MONITORING STANDARDS

Reporting Period	Monitoring Indicator	Threshold	MDHHS Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	MDHHS written notification.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Net Worth	Negative Net Worth	MDHHS written notification. Freeze auto assigned enrollees.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial	Medical Loss Ratio	85%	Below 85%: Remit difference to MDHHS	If the Contractor fails to meet the Medical Loss Ratio threshold, the Contractor: 1. Will remit back to MDHHS a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 85% multiplied by the revenue paid to the Contractor during the contract year.
Annual Financial	Dental Claims Loss Ratio	80%	70%-79.9%- Remit 50% difference to MDHHS Below 70%- Remit 100% difference to MDHHS	If the Contractor fails to meet the Dental Claims Loss Ratio threshold, the Contractor: 1. Will remit back to MDHHS a rebate in the amount equal to the difference between the calculated dental claims loss ratio and the target loss ratio of 80% multiplied by the revenue paid to the Contractor during the contract year.
Annual Financial Statement	Risk Based Capital (RBC)	150-200% RBC	MDHHS written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	RBC	100-149% RBC	MDHHS written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	RBC	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

APPENDIX 3: FY 2025 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

These reports must be submitted in addition to contract compliance review submission requirements.
All reports must be **shared** electronically via the **MDHHS File Transfer Application**.

Exceptions are the encounter data, provider file, and PCP Submission file which are submitted electronically via the FTS.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
DUR Report	TBD based upon additional CMS information to the State		Contract, Section 1.1.VI.D.
APM Data Collection Tool	Preliminary: 4/11/2025 Final: 5/23/2025	1/1/2024 – 12/31/2024	MDHHS Template
APM Quality Impact Analysis	Preliminary: 8/1/2025 Final: 9/12/2025	1/1/2024 – 12/31/2024	MDHHS Template
Medicaid Health Equity Template	8/15/2025	1/1/2024 – 12/31/2024	MDHHS Template
Health Plan Abortion Report	10/5/2025	10/1/2024 – 9/30/2025	MSA-0128 accompanied with all MSA-4240s
Estimate of Community Reinvestment Obligation	11/15/2025	10/1/2024 – 9/30/2025	MDHHS Template
Community Reinvestment Spending Plan	12/1/2025	10/1/2025 – 9/30/2026 (1-year Investment Period) OR 10/1/2025 – 9/30/2027 (2-year Investment Period)	MDHHS Template
PCMH Expansion Report	2/15/2026 8/15/2026		MDHHS Template
MLR Report	4/30/2026	10/1/2024 – 9/30/2025	MDHHS Template
Dental Claim Loss Ratio Report	5/1/2026	10/1/2024 – 9/30/2025	MDHHS Template
Community Reinvestment Expenditures Report	4/30/2027	10/1/2025 – 9/30/2026	MDHHS Template
Semi-Annual Submissions			
APM Progress Report	3/30/2025 9/30/2025	1/1/2024 – 12/31/2024	Report in PowerPoint format
Quarterly Submissions (Previous months reporting)			
Financial	March 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	NAIC and DIFS
Grievance/ Appeal	January 30 April 30	October 1 – December 31 January 1 – March 31	MSA-0131

	July 30 October 30	April 1 – June 30 July 1 – September 30	
Third Party Collection	March 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	Report on separate sheet and send with NAIC
Third Party Recovery	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	Contract, Section 1.1.XVIII.G.
Monthly Submissions			
Claims Processing	30 Days after end of the month NOT last day of month	Data covers previous month, i.e. data for Feb. due by 3/30	MSA 2009 (E)
Encounter Data	15th of each month	Minimum of monthly data covers previous month, i.e. Data for Jan. due by 2/15.	837 Format NCPDP Format
Provider Files (4275)	The last Thursday of each month by noon.	Submit all providers contracted with the plan on the date of submission. Submit one file, utilizing the single provider ID	4275 layout and file edits distributed by MDHHS
Medicaid Health Plan Lead Report	1st of each month		MDHHS Excel Layout
Barrier Report for Enrollees in Foster Care	15th of each month	Data covers previous month	MDHHS Template
Network Adequacy Provider (NAP) File	15th of each month	Data covers previous month	MDHHS Template
Weekly Submissions			
PCP Submission Files (5284)	Weekly	Submit all new and end-dated PCP relationships since the previous submission. Submit a complete refresh file during the time period required by MDHHS	5284 layout and file edits distributed by MDHHS

APPENDIX 4: PERFORMANCE MONITORING STANDARDS

MEDICAID MANAGED CARE
Medicaid Health Plans
(Effective October 1, 2024– September 30, 2025)

Appendix 4 - PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Medicaid Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance is shared with Medicaid Health Plans and compares performance of each plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following:

- **Healthy Michigan Plan (HMP) Measures**
- **MDHHS Dental Measures**
- **CMS Core Set Measures / HEDIS / Managed Care Quality Measures**
- **Maternal Health Measures**
- **Chronic Conditions Measures**

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

Minimum performance monitoring standards for FY 2025 are included in this document. Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract.

MDHHS Dental Measures, some Maternal Health Measures, and some Chronic Conditions Measures are run with custom coded queries.

DENTAL MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Diagnostic Dental Services	All members who are enrolled in the adult dental benefit under the MHP and who received at least one diagnostic dental service within the measurement period.	**≥30%**	MDHHS Data Warehouse	Quarterly
Preventive Dental Services	All members who are enrolled in the adult dental benefit under the MHP and who received at least one preventive dental service within the measurement period.	**≥17%**	MDHHS Data Warehouse	Quarterly
Restorative (Dental Fillings) Services	All members who are enrolled in the adult dental benefit under the MHP and who received at least one restorative (dental fillings) dental service within the measurement period.	**≥14%**	MDHHS Data Warehouse	Quarterly
Diabetic Diagnostic Dental Exam	All members who are enrolled in the adult dental benefit under the MHP with Type 1 or Type 2 diabetes, and who received at least one diagnostic dental service within the measurement period.	**>30%**	MDHHS Data Warehouse	Quarterly
Diabetic Preventive Dental Visit	All members who are enrolled in the adult dental benefit under the MHP with Type 1 or Type 2 diabetes, and who received at least one preventive dental service within the measurement period.	**≥17%**	MDHHS Data Warehouse	Quarterly
Diabetic Restorative Dental Visit	All members who are enrolled in the adult dental benefit under the MHP with Type 1 or Type 2 diabetes, and who received at least one restorative dental service within the measurement period.	**Informational Only**	MDHHS Data Warehouse	Quarterly

*If the MHP does not meet the Restorative (Dental Fillings) services, but meeting the diagnostic and preventive benchmarks, then the MHP meets the standard for restorative services.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Diagnostic Dental Visits in Pregnancy	All pregnant members who are enrolled for adult dental benefit under the MHP who received at least one diagnostic dental service during their pregnancy or 90 days postpartum.	**≥ 30%**	MDHHS Data Warehouse	Quarterly
Preventive Dental Visits in Pregnancy	All pregnant members who are enrolled in the adult dental benefit under the MHP and who received at least one preventive dental service during their pregnancy or 90 days postpartum.	**≥17%**	MDHHS Data Warehouse	Quarterly
Restorative Dental Visits in Pregnancy	All pregnant members who are enrolled in the adult dental benefit under the MHP who received at least one restorative dental service during their pregnancy or 90 days postpartum.	**Informational Only**	MDHHS Data Warehouse	Quarterly
Adults: Any Dental Visit	All members who are enrolled in the adult dental benefit under the MHP and who received had at least one dental service within the measurement period.	**>25%**	MDHHS Data Warehouse	Quarterly
Emergency dental follow-up in all adults in the Adult Dental program	All members who are enrolled in the adult dental benefit under the MHP who visited the Emergency dental room and who received a routine dental visit with a dentist in a dental office for a comprehensive or periodic oral diagnostic visit within 90 days of the emergency visit for dental.	**≥50%**	MDHHS Data Warehouse	Quarterly
Care Continuity	All members enrolled in the adult dental benefit under the MHP for two consecutive years and received a comprehensive or periodic oral evaluation in both years	**≥20%**	MDHHS Data Warehouse	Quarterly
Usual Source of Service	All members who have been enrolled in the adult dental benefit under the MHP for two consecutive years who visited the same practice or clinical entity in both years	**Informational Only**	MDHHS Data Warehouse	Quarterly

CMS CORE SET / HEDIS / MANAGED CARE QUALITY MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Developmental Screening	Children less than one (1) year old who had a developmental screening	**≥34%** First year of life	MDHHS Data Warehouse	Quarterly
	Children between their 1st and 2nd birthday who receive a developmental screening	**≥40%** Second year of life		
	Children between their 2nd and 3rd birthday who receive a developmental screening	**≥33%** Third year of life		
Live Births Weighing Less Than 2,500 Grams (Low Birth Weight)	The percentage of live births that weighed less than 2,500 grams during the measurement period.	**≤8%** (Reverse Measure)	MDHHS Data Warehouse	Quarterly
Diabetes Short-Term Complications Admission Rate	The rate of members in a health plan ages 18+ who were discharged for diabetes short-term complications per 100,000 member months.	**≤18.00** (Reverse Measure)	MDHHS Data Warehouse	Quarterly
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	The rate of members in a health plan ages 40+ who were discharged for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months.	**≤47.00** (Reverse Measure) Informational Only	MDHHS Data Warehouse	Quarterly
Heart Failure Admission Rate	The rate of members in a health plan ages 18+ who were discharged for heart failure per 100,000 member months.	**≤21.00** (Reverse Measure)	MDHHS Data Warehouse	Quarterly
Asthma in Younger Adults Admission Rate	The rate of members in a health plan, ages 18 to 39 who were discharged for asthma 100,000 member months.	**≤4.50** (Reverse Measure)	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Breast Cancer Screening	Women enrolled in a health plan, ages 50 to 74, who received a mammogram to screen for breast cancer during the measurement period or the two (2) years prior to the measurement period.	**≥59%**	MDHHS Data Warehouse	Quarterly
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Members who had new substance use disorder (SUD) episodes that result in treatment initiation and engagement.	**No contractually required minimum; refer to Appendix 5E for withhold benchmarks**	MDHHS Data Warehouse	Quarterly
Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	**≥80%**	MDHHS Data Warehouse	Quarterly
Outreach and Engagement to Facilitate Entry to Primary Care	Members who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who did not have an ambulatory or preventive care visit the month prior to entering the program.	**No contractually required minimum; refer to Appendix 5C for withhold benchmarks**	MDHHS Data Warehouse	Quarterly

MATERNAL HEALTH MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Prenatal Immunization Status	Pregnant members who received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations during the measurement period.	**≥20%**	HEDIS IDSS Data	Annually
Prenatal Depression Screening and Follow-Up	Members who were screened for clinical depression while pregnant, and if screened positive, received follow up care.	Depression Screening: **≥6%** Follow-up on a Positive Screening: **≥60%**	HEDIS IDSS Data	Annually
Postpartum Depression Screening and Follow-Up	Members who were screened for clinical depression during the postpartum period, and if screened positive, received follow up care.	Depression Screening: **≥5%** Follow-up on a Positive Screening: **≥71%**	HEDIS IDSS Data	Annually
Prenatal and Postpartum Care: Postpartum Care (PPC)	Members with delivery of a live birth who received a postpartum visit on or between 7 and 84 days after delivery.	**≥68%**	MDHHS Data Warehouse	Quarterly
Contraceptive Care – Postpartum Women (CCP)	Women between the ages of 15 and 44 who had a live birth, that were provided a most effective or moderately effective method of contraception within 3 and 90 days of delivery.	Age 15-20 Rates 3-Days: ≥7% 90-Days: ≥45% Age 21-44 Rates 3-Days: ≥12% 90-Days: ≥≥43%	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Pregnancy Management	Pregnant members who received the following services: 1. Pregnant members that had HIV testing. 2. Pregnant members less than 25 years of age that had chlamydia screening. 3. Pregnant members that had syphilis screening. 4. Pregnant members that had HBsAg testing. 5. Pregnant members that received Group B Streptococcus testing. 6. Pregnant members less than 25 years of age that had gonorrhea screening 7. Pregnant members that had HIV testing in the 1st or 2nd trimester AND another HIV test in the first or second month of the 3rd trimester. 8. Pregnant members that had HBsAg testing in the 1st or 2nd trimester AND another HBsAg test in the first or second month of the 3rd trimester. 9. Pregnant members that had a syphilis screening in the 1st or 2 and trimester AND another syphilis screening in the first or second month of the 3rd trimester	**No contractually required minimum; refer to Appendix 5C for withhold benchmarks**	MDHHS Data Warehouse	Quarterly
Tobacco Use: Screening and Cessation Intervention	Pregnant members who are current tobacco users and who received medical assistance for tobacco use cessation during their pregnancy or 90 days postpartum.	**≥24%**	MDHHS Data Warehouse	Quarterly

CHRONIC CONDITIONS MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Blood Pressure Control for Members with Hypertension and Diabetes and/or Chronic Kidney Disease	Members between the ages of 18 and 85 years of age with hypertension and diabetes mellitus and/or CKD with most recent blood pressure less than 140/90 mm Hg in the last 12 months.	**≥72%**	MDHHS Data Warehouse	Quarterly
Diabetes Continuous Glucose Monitoring	Members between the ages of 18 and 75 taking insulin with evidence of self-monitoring for blood glucose testing via continuous glucose monitoring.	**Informational Only**	MDHHS Data Warehouse	Quarterly
Lifetime Hepatitis C Screening	Members 18 years of age and older who have received at least one screening for Hepatitis C at any time during the measurement period.	**≥33%**	MDHHS Data Warehouse	Quarterly
Hepatitis C Screening During Pregnancy	The percentage of women who had a live birth who were screened for hepatitis C during their pregnancy.	**≥57%**	MDHHS Data Warehouse	Quarterly
Hepatitis C Treatment	Members ages 3 years of age and older who have been diagnosed with Hepatitis C and have received one or more prescriptions for direct-acting antiviral medication during the measurement period.	**≥42%**	MDHHS Data Warehouse	Quarterly

APPENDIX 5: PERFORMANCE BONUS (QUALITY WITHHOLD)

Overview of Performance Bonus Withhold

Withhold Program Component / Appendix 5 Section	Percentage of Performance Bonus Withhold
Section 5A: Performance Bonus Template	30%
Section 5B: Encounter Quality Initiative (EQI)	7%
Section 5C: Population Health Management (PHM)	10%
Section 5D: Pay for Performance (P4P) – Healthy Michigan Plan (HMP) Cost-Sharing and Value-Based Services	25%
Section 5E: Integration of Mental Health and Physical Health Services (“Shared Metrics”)	13%
Section 5F: Alternative Payment Model (APM)	15%

APPENDIX 5A- Performance Bonus Template

Section	Points Possible
Section 1.1 Membership-Wide Scoring	18 points possible
Section 1.2 Health Equity Scoring	20 points possible
Section 2.0 Low Birth Weight	20 points possible
Section 3.0 Regional Collaboratives	12 points possible
Performance Bonus Template Score	70 points possible

SECTION 1.0: Cumulative List of HEDIS Measures

Measure Name	Included As Part of Membership-Wide Scoring (Section 1.1)	Included As Part of Health Equity Scoring Category (Section 1.2)
Adults' Access to Preventive/Ambulatory Health Services – 20–44-year-old (AAP-2044)	●	●
Asthma Medication Ratio (AMR-ALL)	●	●
Controlling High Blood Pressure (BCP-RPTD)	●	●
Eye Exam for Patients with Diabetes (EED)	●	●
Lead Screening in Children (LSC-CH)	●	●
Children Immunization Combo 3 (CIS-COM3)	●	●
Chlamydia Screening in Women – Total (CHL-AD)		●
Prenatal and Postpartum Care - Postpartum Care (PPC-AD)	●	●
Well-Child Visits in the First 30 months of Life – Rate 1 (W30-015)	●	●
Kidney Health Evaluation for Patients with Diabetes - **Total all ages (KED-AD)**	●	●
Social Needs Screening and Intervention (SNS-E)	Informational Only	
Follow-Up After Hospitalization for Mental Illness- Total (FUH)	Informational Only	
Follow-Up After Emergency Department Visit for Mental Illness- Total (FUM)	Informational Only	

SECTION 1.1: Membership-Wide Scoring

Points possible from this section: 18 points

Medicaid Health Plan	2023 HEDIS Rate	90th Percentile – 2 points75th Percentile – 1.5 points 50th Percentile – 1 point Stat. Sig. Improvement* - 0.5 points	50th Percentile**	75th Percentile**	90th Percentile**
See included measures listed in Section 1.0					

***** Based on MDHHS Chi-Square methodology

** Based on 2023 NCQA Medicaid Percentiles National: HMO Average

SECTION 1.2: Health Equity Scoring

Points possible from this section: 20 points

Health Equity – Stat. Sig. Improvement*	1 point for statistically significant improvement in rate disparity between African American and White beneficiaries***		1 point for statistically significant improvement in rate disparity between Hispanic and White beneficiaries***	
Medicaid Health Plan	2023 African American rate**	2024 African American rate**	2023 Hispanic rate**	2024 Hispanic rate**
See included measures in Section 1.0	Rules and exclusions: 1. If no racial health disparity existed for the African American or Hispanic subpopulation in the 2023 and 2024 measurement periods, the plan will be awarded 1 point for the particular cohort 2. Plans will be given ½ points for each measure that does not reach one of the following thresholds. *** a. If the measure subpopulation numerator is less than 5 b. If the measure subpopulation denominator minus numerator is less than 5 c. If the measure subpopulation denominator is less than 30		Rules and exclusions: 1. If no racial health disparity existed for the African American or Hispanic subpopulation in the 2023 and 2024 measurement periods, the plan will be awarded 1 point for the particular cohort 2. Plans will be given ½ points for each measure that does not reach one of the following thresholds*** a. If the measure subpopulation numerator is less than 5 b. If the measure subpopulation denominator minus numerator is less than 5 c. If the measure subpopulation denominator is less than 30	

***** Based on MDHHS Chi-Square methodology

** Based on MDHHS Data Warehouse Symmetry racially stratified information

***Plans that do not earn back their full withhold amount, will be eligible to petition MDHHS. If it is established that Section 1.2 (½) point scoring is the **only** reason MHPs are not earning full withhold amounts, MHPs will be exempt from scoring and may potentially earn additional points towards their total scores

Section 2.0: Low Birth Weight (LBW) Measure

Points possible from this section: 20 points

LBW-CH measure scoring: “Live Births Weighing Less Than 2,500 Grams” *	Points possible
Benchmark of 13.5% for African American rate	5 points
Plan LBW rate below state median rate using CY24 data	5 points
Plan LBW showing statistically significant improvement between the African American & White rates between CY23 and CY24**	5 points
Plans showing statistically significant improvement by region between African American & White rate between CY23 and CY24**	5 points
LBW Narrative	Required submission; no points assigned

* Based on CMS Child Core Set reported rate

** Calculated using MDHHS Chi-Square methodology. To account for small denominators in the Region 1, 2 and 3, and for UPHP, given that the African American and Hispanic populations have numerators that are less than 5, or have denominators less than 30. Instead, an aggregation of the African American, Hispanic, Asian American, Native American and Pacific Islander/Hawaiian populations will be used (i.e. a “minority” rate)

Section 3.0: Regional Collaboratives

Points possible from this section: 12 points

Activities: MDHHS will send a narrative template for plans to complete. There will be one submission for this activity.

- Template Submission due date: September 30, 2025, before 5:00 pm EST

Scoring rubric: Plans can earn up to 12 points. Scoring will be assessed as follows:

-

Region 1 Collaborative Details- Childhood Immunizations Combo 7

- Points possible: 12. Performance period: Calendar Year 2024The plan achieves statistically significant improvement Childhood Immunizations Combo 7 compared to the prior reporting year or achieve a performance rate of 59.37% (2023 National HEDIS Medicaid 75th percentile). (5 points)
- Disparities between the white reference population versus all minorities is addressed (there must be no statistically significant difference based on the chi square methodology). (2 points). If this goal is not achieved, plan can earn 1 point by submitting a detailed project plan to address disparities during the following measurement year.
- Plan satisfactorily addresses all community outreach expectations as described in the project template (5 points).

Region 10 Collaborative Details- Pediatric Sickle Cell Improvement Project

- Points Possible: 12 points possible (4 possible points per measure). MDHHS will provide Region 10 plans with measure specifications and additional detail on data submission timelines.
  - The following Collaborative target (CT) benchmarks apply to each measure.
    - Appropriate Antibiotic Prophylaxis among Children 3 months to 5 years with Sickle Cell Anemia: 15%
    - Use of Hydroxyurea among Children and Adolescents, ages 1 to 18, with Sickle Cell Anemia: 5%
    - Doppler Ultrasonography Screening among Children with Sickle Cell Anemia: 55%
  - Points will be assessed as outlined in the table below.

Achievement	Antibiotics	Hydroxyurea	Doppler Screening

Meet Region 10 CT	1	1	1
Individual plan meets CT	2	2	2
Individual plan exceeds CT by 5-10%	0.5	0.5	0.5
Individual plan exceeds CT by greater than 10%	0.5	0.5	0.5

MDHHS reserves the right to expand the Pediatric Sickle Cell Improvement Project into a statewide quality initiative.

APPENDIX 5B- EQI Requirements

ENCOUNTER QUALITY INITIATIVE (EQI) REQUIREMENTS FOR MEDICAID HEALTH PLANS
Fiscal Year 2025 P4P Program

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

Deliverable/Criteria	**Due Date**	**Total Points**
1. Timely submission of EQI reports (appendices, and reconciliation documents) according to the EQI Schedule	In accordance with the Encounter Quality Initiative Schedule	3
2. Completed reconciliation document, which includes the selection of variances, discussion of how to fix the variances, and information from the DRIVE tool.	In accordance with the Encounter Quality Initiative Schedule	18
	Total	**21**

1. The health plan will receive 3 points total (1 point per due date) for the timely submission of EQI reports and reconciliation documents according with the EQI schedule. Extensions may be granted if the health plan contacts the EQI Administrator more than 24 hours in advance of the due date. If the extension is granted, the extension due date will be the timely submission deadline. To earn points for an on-time submission for each item, the EQI report and the reconciliation template must be received by the close of business on the respective due date.

2. The health plan will receive 18 points (6 points per due date) for the selection and follow-up on variances within the DRIVE tool. For each due date, plans will select two variances for both paid units and paid amounts (4 different variances total) that they intend to show improvement on. The selection of at least 4 variances will amount to 3 points. In the EQI period following the selection of the variances, with 3 points total being awarded for the follow-up on all 4 selected variances. The reconciliation template will be used for these purposes and will be updated accordingly.

APPENDIX 5C- Population Health Management

Population Health Management (PHM)

This appendix features Michigan-specific custom quality measures and projects supporting populations with unique characteristics.

FY25 PHM DELIVERABLES	***POINT ALLOCATION***	***SUBMISSION DATE***
Social Determinants of Health Excel *MHPs must submit CY24 screening & referral data tool and demonstrate that they met specified benchmarks*	10	September 27, 2025
Social Determinants of Health Referral Capacity	5	September 27, 2025
Pregnancy Management Measure	8	Performance will be based on July 2025 PMR
HIV Provider Outreach Project	5	See project template for timeline
LGBTQ Care Quality Improvement Project	5	August 30, 2025
Outreach and Engagement to Facilitate Entry into Primary Care	2	N/A
TOTAL POINTS:	***35***	

Social Determinants of Health

Health plans will use CY24 data to complete a spreadsheet provided by MDHHS.

A. *Scoring rubric*:

Data element	**Benchmarks**	**Possible points**
New Member Screening Rate	≥14%	3
Existing Member Screening Rate	≥10%	3
Total Member Screening Rate	≥10%	4

B. *Performance standards*:
For each data element, plans earn full points if they meet or exceed the benchmark. Alternatively, plans also earn one (1) point if their CY24 performance shows statistically significant improvement from CY23.

C. *Social Needs Screening and Intervention (SNS-E)*:
Health plans must start reporting on NCQA SNS-E measure in FY25 as Informational Only.

D. SDOH Referral Capacity: Health plans must complete an SDOH Referral Capacity Template, including a comprehensive list of resources to meet members' SDOH-related needs for each region they serve (5 points). MDHHS will provide a reporting template for plans to complete.

Pregnancy Management Measure: Health plans must meet the benchmarks below to earn points on this activity.

Data element	Performance standard	Possible points
Pregnant members that had HIV testing.	**90%**	**0.5**
Pregnant members less than 25 years of age that had chlamydia screening.	**90%**	**0.5**
Pregnant members that had syphilis screening.	**90%**	**0.5**
Pregnant members that had HBsAg testing.	**87%**	**0.5**
Pregnant members that received Group B Streptococcus testing.	**80%**	**0.5**
Pregnant members less than 25 years of age that had gonorrhea screening	**90%**	**0.5**
Pregnant members that had a HIV testing in the 1st or 2nd trimester AND another HIV test in the first month of the 3rd trimester	**45%**	**1**
Pregnant members that had a HBsAg testing in the 1st or 2nd trimester AND another HBsAg test in the first month of the 3rd trimester	**35%**	**1**
Pregnant members that had a syphilis screening in the 1st or 2nd trimester AND another syphilis screening in the first month of the 3rd trimester	**45%**	**3**

HIV Provider Outreach Project: The purpose of this project is for plans to participate in community and provider outreach activities that will increase statewide capacity to improve performance on the HIV Viral Load Suppression CMS core set measure. Plans will use a reporting template that the Managed Care quality team will provide to document progress on projects and activities assigned by MDHHS.

Activities: MDHHS will send a template for plans to complete. There will be a pre- and final submission in this activity.

Scoring rubric: MDHHS will award a possible 5 points for satisfactory completion of the pre- and final submissions.

Lesbian, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Improvement Project:

The purpose of the LGBTQ Care Quality Improvement Project is to gain further understanding of the clinical and care management landscape in terms of care coordination and provider competency to address health disparities particular to the LGBTQ population. In FY25, plans will use a reporting template that the Managed Care quality team will provide to document progress on plan projects and activities that address the needs of LGBTQ members.

Activities: MDHHS will send a template for plans to complete. There will be a pre- and final submission in this activity.

- Pre-submission due date: June 27, 2025, before 5:00pm EST
- Final submission due date: August 29, 2025, before 5:00 pm EST

Scoring rubric: MDHHS will award a possible 5 points for satisfactory completion of the pre- and final submissions.

Outreach and Engagement to Facilitate Entry to Primary Care:

Michigan House Bill No. 4495 requires that all new Healthy Michigan Plan Enrollees be assigned and have

scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The Outreach and Engagement to Facilitate Entry to Primary Care measures Healthy Michigan Plan members who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who did not have an ambulatory or preventive care visit the month prior to entering the program.

Measure	Benchmark	Points	Performance Period
Outreach and Engagement to Facilitate Entry to Primary Care (ENT-PC)	35%	2	CY2024

APPENDIX 5D- Dental Quality

Dental Quality

This appendix considers plans' performance on dental quality metrics. MDHHS will calculate performance rates using plan-submitted administrative data. Health plans can earn up to 20 points.

Health plans can earn one (1) point for statistically significant rate improvement, compared to the previous year's rate, if they did not meet any of the set benchmarks for that measure.

Measure name	Description	Benchmarks	Points Possible	Performance period
Diagnostic Dental Services	All members who are enrolled in the adult dental benefit under the MHP who received at least one diagnostic dental service within the measurement period.	≥30% = 2 points ≥36% = 4 points ≥40% = 8 points Statistically Significant Improvement = 1 point	8	FY25 (October 2024-September 2025)
Preventive Dental Services	All members who are enrolled in the adult dental benefit under the MHP who received at least one preventive dental service within the measurement period.	≥17% = 2 points ≥24% = 4 points ≥27% = 8 points Statistically Significant Improvement = 1 point	8	FY25 (October 2024-September 2025)
Diagnostic Dental Visits in Pregnancy	All pregnant members who are enrolled in the adult dental benefit under the MHP and who received at least one diagnostic dental service during their pregnancy or 90 days postpartum.	≥30% = 2 points	2	FY25 (October 2024-September 2025)
Diabetic Preventive Dental Visit	All members who are enrolled in the adult dental benefit under the MHP with Type 1 or Type 2 diabetes, and who received at least one preventive dental service within the measurement period.	≥17% = 2 points	2	FY25 (October 2024-September 2025)

APPENDIX 5E- Performance Bonus

Performance Bonus

Integration of Mental Health and Physical Health Services

To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Pre-paid Inpatient Health Plans (PIHPs), the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

Category	Description	Criteria/Deliverables
1. Implementation of Joint Care Management Processes (30 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and PIHP will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Each MHP and PIHP must demonstrate joint care planning specific to child and adult populations. MHPs and PIHPs must document joint care plans in CC360 for at least 25% of qualified adult Enrollees. Adult Enrollees qualify for the denominator based on eligibility criteria outlined in the CC360: Risk Stratification- Easy Tab Job Aid.
2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) using HEDIS descriptions (30 points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older). The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 79%. Measurement period will be calendar year 2024. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group (if necessary, minority groups will be combined to achieve a sufficient denominator). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024. The points for overall standard (item 1 above) will be awarded based on MHP/PIHP combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or PIHP performance over time. The total potential points

		will be the same regardless of the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons
3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (20 points)	Members who had new substance use disorder (SUD) episodes that result in treatment initiation and engagement.	1. The Contractor will be measured against an initiation (IET 14) minimum standard of 40% (5 points) and an engagement (IET 34) minimum standard of 14% (5 points). Measurement period will be calendar year 2024. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group (if necessary, minority groups will be combined to achieve a sufficient denominator). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024. Addressing disparities for initiation (IET 14) is worth 5 points and addressing disparities for engagement (IET 34) is worth 5 points. The points for overall standard (item 1 above) will be awarded based on MHP/PIHP combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or PIHP performance over time. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons.
4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (20 points)	Members 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	1. Plans will be scored on racial disparities only. The measurement period will be calendar year 2024. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group (if necessary, minority groups will be combined to achieve a sufficient denominator). The measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or PIHP performance over time. The total potential points will be the same regardless of the number of racial/ethnic comparisons.

APPENDIX 5F- Alternative Payment Model

Alternative Payment Model (APM)

Contract Appendix – Pay for Performance Bonus Program FY 25

Medicaid Health Plans (MHPs) have been working towards increasing the use of APMs, with the goal of improving quality of care while better managing costs. The APM deliverables related to the MDHHS Performance Bonus for the FY25 Program are as follows:

Domain	Deliverable	Points	Due Date
APM Strategic Plan	PowerPoint presentation that includes the following information: a) Description of APM progress in CY24: Evaluate APM performance against expectations. b) Evaluation should include analysis on successful strategies, barriers, and lessons learned c) Explain plans to further expand APMs over the course of the next three years.	No points assigned; compliance requirement	Report: Apr.25 Presentations: Apr./May
APM Data Collection Tool	1. Submit CY24 APM Data Collection Tool. Full points will be rewarded based on meeting MDHHS benchmarks (50% Big Numerator; 12.5% in Category 3 & 4; 2.5% in Small Numerator). Partial credit will be given for increasing APM use. 2. Data Validation Review a) Please describe in detail how payments have been categorized into APM categories. b) Please describe the steps the MHP goes through to validate the data is correct. c) Please describe any differences in approach in APM reporting and data validation in CY24 from previous years.	45 Scoring note: 1-point deducted for every 1% under Big Numerator threshold, and 1-point deducted for every 0.5% under Small Numerator threshold.	Pre: Apr.11 Final: May 23
Quality Impact Analysis	Review Quality Performance a) Review progress toward APM quality benchmarks through the APM Quality Template b) Compare performance on measures linked to APMs and those not linked to APMs through the APM Quality Template c) Provide narrative of i. Impact of APM strategy on measure performance ii. Challenges/opportunities in use of APMs to improve performance on targeted measures iii. Changes in performance measures used in APMs in CY24 compared to CY23	45	Pre: Aug. 1 Final: Sept. 12

Domain	Description	Points	Due Date
Care Management & Care Coordination	Measure Specification includes 16 Care Management and Care Coordination codes. Measurement year is October 1, 2024 – September 30, 2025, no continuous enrollment criteria will be applied, and Health Plan Attribution is applied at time of service. Member months will be used to calculate the ratio benchmarks. Historical data was used to determine benchmarks. i. Measure 1: Program Benchmark: For Codes Submitted per 1,000 MM ii. Measure 2: Health Plan Specific Benchmark: # of Codes submitted per 1,000 MM iii. Measure 3: Program Benchmark of Beneficiaries received a CM/CC service iv. Measure 4: Health Plan Specific Benchmark: Percentage of Beneficiaries Served	No points assigned; compliance requirement	Data will be generated by MDHHS
Dental	Contractor must have at least one APM arrangement with a dental provider in place by the end of FY25. Contractor must provide evidence that arrangement is in place.	10	Sept. 30

APPENDIX 6: MATERNITY CASE RATE QUALIFYING ENCOUNTER CODES

Maternity Case Rate Qualifying Encounter Codes

The following are Revenue, Procedure and Diagnosis codes that MDHHS will use to identify qualifying encounters for maternity case rate payments.

Revenue Codes 0 7 2 0 , 0721, 0722, 0724, 0729

Procedure Codes 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, 59871, 59898, 59899

Diagnosis Codes O368310, O368311, O368312, O368313, O368314, O368315, O368319, O368320, 368321, O368322, O368323, O368324, O368325, O368329, O368330, O368331, O368332, O368333, O368334, O368335, O368339, O42011, O42012, O42013, O4202, O4210, O42111, O42112, O42113, O4212, O42911, O42912, O42913, O4292, O43011, O43012, O43013, O43021, O43022, O43023, O43101, O43102, O43103, O43111, O43112, O43113, O43121, O43122, O43123, O43191, O43192, O43193, O43211, O43212, O43213, O43221, O43222, O43223, O43231, O43232, O43233, O43811, O43812, O99411, O99412, O99413, O9942, O9943, O43813, O43891, O43892, O43893, O4391, O4392, O4393, O3121X0, O3121X1, O3121X2, O3121X3, O3121X4, O3121X5, O3121X9, O3122X0, O3122X1, O3122X2, O3122X3, O3122X4, O3122X5, O3122X9, O3123X0, O3123X1, O3123X2, O3123X3, O3123X4, O3123X5, O3123X9, O0941, O0942, O0943, O09511, O09512, O09513, O09521, O09522, O09523, O3131X0, O3131X1, O3131X2, O3131X3, O3131X4, O3131X5, O3131X9, O3132X0, O3132X1, O3132X2, O3132X3, O3132X4, O3132X5, O3132X9, O3133X0, O3133X1, O3133X2, O3133X3, O3133X4, O3133X5, O3133X9, O318X10, O318X11, O318X12, O318X13, O318X14, O318X15, O318X19, O318X20, O318X21, O318X22, O318X23, O318X24, O318X25, O318X29, O318X30, O318X31, O318X32, O318X33, O318X34, O318X35, O318X39, O320XX0, O320XX1, O320XX2, O320XX3, O320XX4, O320XX5, O320XX9, O321XX0, O321XX1, O321XX2, O321XX3, O321XX4, O321XX5, O321XX9, O322XX0, O322XX1, O322XX2, O322XX3, O322XX4, O322XX5, O322XX9, O323XX0, O323XX1, O323XX2, O323XX3, O323XX4, O323XX5, O323XX9, O324XX0, O324XX1, O324XX2, O324XX3, O324XX4, O324XX5, O324XX9, O326XX0, O326XX1, O326XX2, O326XX3, O326XX4, O326XX5, O326XX9, O2201, O2202, O2203, O2211, O2212, O2213, O350XX0, O350XX1, O350XX2, O350XX3, O350XX4, O350XX5, O350XX9, O351XX0, O351XX1, O351XX2, O351XX3, O351XX4, O351XX5, O351XX9, O352XX0, O352XX1, O352XX2, O352XX3, O352XX4, O352XX5, O352XX9, O353XX0, O353XX1, O353XX2, O353XX3, O353XX4, O353XX5, O353XX9, O354XX0, O354XX1, O354XX2, O2221, O2222, O2223, O2231, O2232, O2233, O2241, O2242, O2243, O2251, O2252, O2253, O228X1, O228X2, O228X3, O2291, O2292, O2293, O3621X4, O3621X5, O3621X9, O3622X0, O3622X1, O3622X2, O3622X3, O3622X4, O3622X5, O3622X9, O3623X0, O3623X1, O3623X2, O3623X3, O3623X4, O3623X5, O3623X9, O364XX0, O364XX1, O364XX2, O364XX3, O364XX4, O364XX5, O364XX9, O365110, O365111, O365112, O365113, O365114, O365115, O365119, O365120, O365121, O359XX0, O359XX1, O359XX2, O359XX3, O359XX4, O359XX5, O359XX9, O360110, O360111, O360112, O360113, O360114, O360115, O360119, O360120, O360121, O360122, O360123, O360124, O360125, O360129, O360130, O360131, O360132, O360133, O360134, O360135, O360139, O360910, O360911, O360912, O360913, O360914, O360915, O360919, O360920, O360921, O360922, O360923, O360924, O360925, O360929, O360930, O360931, O360932, O360933, O360934, O360935, O360939, O361110, O2651, O2652, O2653, O365122, O365123, O365124, O365125, O365129, O365130, O365131, O365132, O365133, O365134, O365135, O365139, O365910, O365911, O365912, O365913, O365914, O365915, O365919, O365920, O365921, O365922, O328XX0, O328XX1, O328XX2, O328XX3, O328XX4, O328XX5, O328XX9, O329XX0, O329XX1, O329XX2, O329XX3, O329XX4, O329XX5, O329XX9, O330, O331, O332, O333XX0, O333XX1, O333XX2, O333XX3, O333XX4, O333XX5, O333XX9, O334XX0, O334XX1, O334XX2, O334XX3, O334XX4, O334XX5, O334XX9, O335XX0, O361111, O361112, O361113, O361114, O361115, O361119, O361120, O361121, O361122, O361123, O361124, O361125, O361129, O361130, O361131, O361132, O361133, O361134, O361135, O361139, O361910, O361911, O361912, O361913, O361914, O361915, O30001, O30002, O30003, O30011, O365923, O365924, O365925, O365929, O365930, O365931, O365932, O365933, O365934, O365935, O365939, O3661X0, O3661X1, O3661X2, O3661X3, O3661X4,

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APPENDIX 7: MENTAL HEALTH AUTHORIZATION AND PAYMENT RESPONSIBILITY GRID

Michigan Department of Health and Human Services

Medicaid Mental Health Authorization and Payment Responsibility Grid

Contractor must utilize the Medicaid Mental Health Authorization and Payment Responsibility Grid located in the link below:

Medicaid Mental Health and Substance Use Disorder Authorization and Payment Responsibility Grid

This grid indicates Medicaid Health Plan (MHP) and Prepaid Inpatient Health Plan (PIHP) coverage responsibility for mental health services. It should be utilized by MHPs, PIHPs, Community Mental Health Service Programs, providers and other, as applicable, to determine the responsible entity for authorization and payment of mental health services delivered to Enrollees.

The grid currently delineates coverage responsibility by the setting in which a service is provided. MDHHS intends to modify this policy and grid so that coverage responsibility for mental health services will be determined by the level of Enrollees' needs rather than by the setting in which a service is provided. The grid will be updated in accordance with any change in MDHHS policy.

In addition to this grid, all entities should follow Medicaid policy as described in the Medicaid Provider Manual and the entity's contract with the State and as directed by MDHHS.

APPENDIX 8: MEDICAID MENTAL HEALTH SUBSTANCE USE DISORDER INPATIENT MEDICAL ACUTE DETOXIFICATION POLICY

Inpatient Medical Acute Detoxification is the responsibility of the Michigan Department of Health and Human Services (MDHHS). Complete details on the policy covering this service can be found in the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of the Medicaid Provider Manual. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual >> Medicaid Provider Manual.

For admission to an acute care setting for a diagnosis of substance use disorder, the individual must meet at least one of the following criteria as reflected in the physician's orders and patient care plan. These criteria may be revised so it is important to refer to the Medicaid Provider Manual for current criteria list.

- Vital signs, extreme and unstable.
- Uncontrolled hypertension, extreme and unstable.
- Delirium tremens (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance use disorder. With pregnancy, monitoring the fetus is vital to the continued health of the fetus.
- Insulin-dependent diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an urgent/emergent condition.

Clarification of Inpatient Detox

- Acute medical detoxification services are reimbursed directly by Medicaid fee-for-service (FFS).
- Medicaid FFS covers inpatient hospitalization designed for the purpose of detoxification in an inpatient setting. The primary diagnosis on the claim must document that the hospitalization was for the sole purpose of providing an inpatient setting for detoxification. Medically necessary inpatient detoxification is only allowed under Medicaid policy in a life-threatening situation. Medicaid does not cover inpatient detoxification if the individual is not in a life-threatening situation or otherwise incapacitated.
- The MHP is not responsible for inpatient hospitalization if the individual is hospitalized due to the withdrawal of a substance of abuse (e.g., narcotics, alcohol, etc.). If detoxification has led to a life-threatening situation, MDHHS is responsible for the claim. Life-threatening situations are well defined in the Medicaid Provider Manual in the Hospital chapter.
- The MHP covers inpatient hospitalization if the individual is hospitalized for medical complications caused by substance use disorder. In these cases, the primary diagnosis must reflect the medical problem for which the individual was admitted. Substance use disorder may appear as a diagnosis other than primary; however, the existence of substance use disorder as a diagnosis other than primary does not render the hospitalization payable by Medicaid FFS.
- Authorization is required for all inpatient admissions for medical conditions.

APPENDIX 9: PIHP-MHP MODEL AGREEMENT

PIHP-MHP Model Agreement Website Version FINAL CLEAN (michigan.gov)

APPENDIX 10: HIPAA BUSINESS ASSOCIATE AGREEMENT

HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the Michigan Department of Health and Human Services and _____.

RECITALS

A. Under this Agreement, the Business Associate 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 the 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 the Business Associate before the Business Associate'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 **[Insert Name of Business Associate]**.

c. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this 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.

Business Associate 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 must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of the Business Associate's operations and the nature and the scope of its activities.

c. report to the Covered Entity within 24 hours of any use or disclosure of PHI not provided for by 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 the Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and the Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

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

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

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under, 45 CFR § 164.526. If any individual requests an amendment of PHI directly from the Business Associate or its agents or subcontractors, the Business Associate must notify the Covered Entity in writing within five days of the request and amend the information within ten days of the request. Any denial of amendment of PHI maintained by the Business Associate or its agents or subcontractors is the responsibility of the Business Associate.

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 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 agrees to implement a process that allows for an accounting to be collected and maintained by the Business Associate and its agents or subcontractors for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the written request for disclosure. If the request for an accounting is delivered directly to the Business Associate or its agents or subcontractors, the Business Associate must, within ten days of the receipt of the request, forward it to the Covered Entity in writing.

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

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

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

k. implement policies and procedures for the final disposition of 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, the Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Agreement. Business Associate 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 the Business Associate to which the Covered Entity has access during the course of such inspection. Covered Entity and the Business Associate 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, the Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve the Business Associate of its responsibility to comply with this 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 may use or disclose PHI:

(1) for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; provided, however, either (A) the disclosures are required by law, or (B) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(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 the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

(5) for any other purpose listed here: **[describe how Business Associate will use and/or disclose PHI under this Agreement]**.

b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations

Covered entity agrees to:

a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to the Business Associate under this Agreement until the PHI is received by the Business Associate.
b. provide the Business Associate with a copy of its Notice of Privacy Practices and must notify the Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.
c. notify the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect the Business Associate's use or disclosure of PHI.
d. notify the Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

5. Term. This 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 the Business Associate of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreement and provides grounds for the Covered Entity to terminate this Agreement for cause. Termination for cause is subject to 6.b.:

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

(2) Business Associate's Duties. Notwithstanding termination of the Agreement, and subject to any directions from the Covered Entity, the Business Associate must protect and preserve property in the possession of the Business Associate in which the Covered Entity has an interest.

(3) Erroneous Termination for Default. If the Covered Entity terminates this Agreement under Section 6(a) and after such termination it is determined, for any reason, that the Business Associate 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 knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement under Section 6(a), then the Covered Entity must notify the Business Associate of the pattern of activity or practice. The Business Associate must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate's efforts to cure such breach or end such violation are unsuccessful, the Covered Entity may either (i) terminate this Agreement, if feasible or (ii) report the Business Associate'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 the Business Associate on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
(2) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;
(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 the Business Associate retains the PHI;
(4) not use or disclose the PHI retained by the Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1)

which applied before termination; and

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

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

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

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

10. Certification. If the Covered Entity determines an examination is necessary to comply with the Covered Entity's legal obligations under HIPAA relating to certification of its security practices, the Covered Entity or its authorized agents or contractors, may, at the Covered Entity's expense, examine the Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Covered Entity the extent to which the Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this 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) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA or the HIPAA Rules.

12. Assistance in Litigation or Administrative Proceedings. Business Associate must make itself, and any subcontractors, employees or agents assisting the Business Associate in the performance of its obligations under this Agreement, available to the Covered Entity, at no cost to the Covered Entity, to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against the Covered Entity, 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 the Business Associate's or its subcontractors use or disclosure of PHI under this Agreement, except where the Business Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer

upon any person other than the Covered Entity, the Business Associate 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'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.

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, sent by certified or registered mail to the representatives at the addresses set forth below or sent via email to the Privacy Security Mailbox at MDHHSPrivacySecurity@michigan.gov.

Covered Entity Representative:

James Bowen
Privacy and Security Manager
MDHHS Compliance Office
333 South Grand Ave, 4th Floor
Lansing, MI 48933
(517) 284-1018

Business Associate Representative:

Name:
Title:
Department:
Address:
Phone:
Email:

Name:
Title:

Department:
Address:
Phone:
Email:

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.

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

Covered Entity

[INSERT NAME]

By:_____

Date: _____

Print Name: Tony Weber

Title: Chief Compliance Officer

APPENDIX 11: STATE LABORATORY SERVICES

Test	Current Procedure Terminology (CPT) Code
Chlamydia Nucleic Acid Amplification Test (NAAT)	87491
Gonorrhea NAAT	87591
Hepatitis B	86706, 87340
Hepatitis C	86803, 86804
Fungal identification	87107, 87101, 87102
Yeast identification	87106
Ova and Parasite	87169, 87172, 87177, 87206, 87207, 87209
Bacterial identification	87077
Mycobacteria culture	87116, 87015, 87206
M. tuberculosis Amplified Probe	87556
Blood lead	83655
Trichomonas NAAT	87661
Severe Acute Respiratory Syndrome Coronavirus 2, (COVID-19) Antibody	86328, 86408, 86409, 86413, 86769, 87426, 87428, 87635, 87636, 87637, 87811, U0001, U0002, U0003, U0004, U0005

APPENDIX 12: COMMUNITY REINVESTMENT GUIDE

Community Reinvestment
PURPOSE

This Appendix, in conjunction with Section 4.1.VII and DEFINITIONS, specifies requirements for the Contractor to reinvest a portion of its profits into the local communities in which it operates. The goal of the Community Reinvestment requirement is to build community capacity to address Enrollees' Health-Related Social Needs (HRSN), with a focus on food insecurity and housing instability, as well as the capacity of Community-based Organizations (CBOs) to offer nutrition in lieu of services (ILOS).

REQUIREMENTS

1. Calculating the Community Reinvestment Obligation

The Community Reinvestment Obligation is assessed on profit accrued during the contract year (October 1 – September 30) and is equivalent to five (5) percent of annual pre-tax profit. All income, including investment income, must be included in the calculation of the Community Reinvestment Obligation, and it must be assessed prior to all state and federal taxes.

Profit, for purposes of the Community Reinvestment policy, represents MHP reported revenues in excess of reported plan program expenditures as identified through MDHHS reporting. MDHHS reporting will reflect the Medical Loss Ratio Template Modified to include non-benefit expenses for purposes of calculating profits to be used in identifying any Community Reinvestment Obligation. As such, profit includes underwriting gains considering both benefit and non-benefit expenses.

Beginning November 15, 2025, and annually thereafter, the Contractor will submit an initial estimate of its Community Reinvestment Obligation in a format prescribed by MDHHS.

On April 30, 2026, and annually thereafter, the Contractor will complete the Medical Loss Ratio (MLR) template provided by MDHHS. MDHHS will use the financial information reported in the MLR template to confirm the Community Reinvestment Obligation, which will be communicated to the Contractor by July 1, 2026 and annually thereafter. For example, MDHHS will communicate the Contractor's Community Reinvestment Obligation for profit accrued from October 1, 2024 to September 30, 2025 to the Contractor by July 1, 2026.

2. Timing of Community Reinvestment

The Investment Period begins October 1 immediately following the contract year on which the Community Reinvestment Obligation is assessed. The Contractor must expend all of its Community Reinvestment Obligation within the designated Investment Period and is not permitted to carry over unspent funds into future Investment Periods. The Contractor is permitted to make investments at any time within the Investment Period, but only investments approved by MDHHS via the Community Reinvestment Spending Plan will be counted toward compliance with the Community Reinvestment requirements.

The Contractor will have a one- or two-year Investment Period, dependent on the amount of the Contractor's calculated Community Reinvestment Obligation.

If the Community Reinvestment Obligation is equal to or less than $200,000, the Contractor will have one year to invest. For example, if the Contractor's Community Reinvestment Obligation for the first contract year (October 1, 2024 – September 30, 2025) was $200,000 or less, the Investment Period would be one year from October 1, 2025 to September 30, 2026.

If the Community Reinvestment Obligation is greater than $200,000, the Contractor will have two years to invest. For example, if the Contractor's Community Reinvestment Obligation for the first contract year (October 1, 2024 – September 30, 2025) is greater than $200,000, the Investment Period would be two years from October 1, 2025 to September 30,

2027.

If the Contractor has two years to invest, the Contractor must invest a minimum of $200,000 in the first year of the two-year Investment Period or 50% of its Community Reinvestment Obligation, whichever is greater. The Contractor is not prohibited from investing all of its Community Reinvestment Obligation in the first year of the Investment Period.

3. Allowable Activities

The Contractor's Community Reinvestment Obligation is intended to address Social Determinants of Health and HRSN. A minimum of 60% of the total Community Reinvestment Obligation must be invested in activities that address food insecurity. The minimum percentage will be calculated across all of the Contractor's reinvestments, not by Region. The remaining amount can support activities that address food insecurity or housing instability.

Consistent with activities that address food insecurity, the Contractor is encouraged to fund activities that support the ability of CBO(s) to offer nutrition ILOS. The Contractor cannot, however, use its Community Reinvestment Obligation to pay for any Covered Services or ILOS or to fulfill other contractual requirements.

To the extent possible, the Contractor is encouraged to work with other Contractors in or near their Service Area to maximize the collective impact of activities funded with its Community Reinvestment Obligation.

Activities that the Community Reinvestment Obligation can support include but are not limited to:

- Software for necessary technology for a CBO to bill the Contractor for ILOS provided.
- Vehicle(s) for a CBO to deliver nutritious meals to individuals in the community.
- Nutrition counseling services that are provided with a produce prescription.
- Kitchen supplies to support food preparation or operational capacity.
- Local housing authority home repairs.
- A daytime drop-in service center that provides first emergency housing vouchers and help with housing applications.

Activities that the Community Reinvestment Obligation cannot support include but are not limited to:

- Payment for healthy food packs provided as an ILOS.
- Care management services, as required under Section 1.1.X.D.1.
- Community Health Worker services, as required under Section 1.1.VIII.A.3.
- Screenings for Health Related Social Needs, as required under Section 1.1.V.S.3.c.
- Evaluation of the impact of activities funded by the Community Reinvestment Obligation.
- Member incentives to access Covered Services.

4. Eligible Organizations

The entire Community Reinvestment Obligation must be distributed to CBO(s). The Contractor cannot have a full or partial ownership stake or any financial interest in the CBO(s) it invests in. Funds from the Community Reinvestment Obligation given to a CBO in which the Contractor has an ownership or financial interest will not count toward the community reinvestment requirement.

To be eligible to receive a portion of the Community Reinvestment Obligation, a CBO must:

- Meet the definition of a CBO, as defined in this contract;
- Deliver services or administer programs that address the HRSNs of Enrollees in the Region(s) the Contractor serves;
- Have a physical presence in Michigan, defined as having one or more office locations in Michigan and preferably in the Region(s) the Contractor serves; and

- Participate in the local Michigan food economy, if the CBO is focused on addressing food insecurity.

A CBO that receives a portion of the Community Reinvestment Obligation is intended to be a non-clinical partner. However, a CBO that offers clinical and non-clinical services (e.g., a housing organization with a health clinic) is an appropriate organization to receive a portion of the Community Reinvestment Obligation.

The Contractor must have a written agreement in place with a CBO prior to disbursing funds. Written agreements could include, but are not limited to, a contract, memorandum of understanding or grant agreement. Regardless of format, the written agreement must include:

- Legal names for all entities;
- Contract term, budget and funding distribution schedule;
- The scope of work, including the specific items, activities and/or services to be funded;
- A plan for collecting and sharing data, as applicable to each funded project.

Written agreements between the Contractor and CBO(s) must be made available to MDHHS within 30 calendar days upon request.

5. Community Reinvestment Spending Plan

Beginning December 1, 2025, and annually thereafter, the Contractor must submit an annual Community Reinvestment Spending Plan ("the Plan") using a template provided by MDHHS. The Plan will cover how the Contractor will allocate its Community Reinvestment Obligation accrued in the prior contract year. For example, the Plan submitted on December 1, 2025 will outline how the Contractor will invest the Community Reinvestment Obligation accrued from October 1, 2024 through September 30, 2025 during the designated Investment Period.

The Plan must include information on which CBO(s) the Contractor will invest in and what activities the investments will support. For each CBO that receives a portion of the Community Reinvestment Obligation, the Contractor's Plan must include:

- The name of the CBO to receive funding, its address and the Region(s) in which it is located;
- An attestation that the Contractor does not have a full or partial ownership stake or any financial interest in the CBO;
- The activities the CBO will carry out and which HRSN(s) it addresses
- What issue the activities address, and how the issue was identified;
- How the community was engaged in the development, selection and finalization of the CBO(s) or activities;
- Whether and how the project addresses the systems and capacity of local CBOs to provide ILOS;
- Any partners co-funding or supporting implementation of the activities (including but not limited to other Contractors); and
- Anticipated outcomes from the activities and how the Contractor will measure success.

The Contractor must fund at least one CBO with a physical location in each Region they are contracted to serve. The proposed activities detailed in the Plan should supplement, not supplant, existing activities and funding relationships between MHPs and CBOs. The Contractor is not required to report the amount of funding to be distributed to each CBO in the Plan.

MDHHS will approve the Plan or request edits within 60 days of Contractor submission. Once approved by MDHHS, the Plan will be publicly available on MDHHS' website.

If the Contractor needs to modify the Plan due to a change in activities or CBO(s) that occurs after approval by MDHHS, the Contractor must resubmit an updated Plan to MDHHS for approval. If the Contractor is submitting an amended Plan, all template elements listed above would be required to be completed, along with a description of the change(s) and rationale for the change(s). Amendments, if applicable, must be submitted on a quarterly schedule to MDHHS by the

following deadlines:

- March 1
- June 1
- September 1

MDHHS will issue an approval or request edits within 60 days of each deadline. If an extenuating circumstance emerges, the Contractor may request an exceptions approval in order to submit an amendment on an off-cycle date.

6. Community Reinvestment Expenditures Report

Beginning April 30, 2027, and annually thereafter, the Contractor must submit a Community Reinvestment Expenditures Report ("the Report") using a template provided by MDHHS. The Report will cover investments made in the prior contract year, as outlined in Appendix 3. For example, the Report submitted on June 1, 2027 will cover investments in CBOs between October 1, 2025 through September 30, 2026.

Beginning with the Report submitted April 30, 2028, the Report may cover investments made during the same contract year that apply to different, but overlapping, Investment Periods. For example, the April 30, 2028 submission will cover investments made from October 1, 2026 through September 30, 2027, which could count toward spending down the Community Reinvestment Obligation for:

- The first contract year (Investment Period, if two years: October 1, 2025 – September 30, 2027); and
- The second contract year (Investment Period, if two years: October 1, 2026 – September 30, 2028).

The Report template will delineate how to separate expenditures based on the Investment Period they apply to.

For each CBO that receives a portion of the Community Reinvestment Obligation, the Report must include:

- The name of the CBO that received funding, its address and the Region(s) in which it is located;
- An attestation that the Contractor does not have a full or partial ownership stake or any financial interest in the CBO;
- The amount of funding the CBO received;
- The activities the CBO carried out using its portion of the Community Reinvestment Obligation, and which HRSN(s) it addressed;
- Any outcomes associated with the activities, including, if relevant, how they impacted community capacity to address ILOS.

The funded CBO(s) and activities must align with the Plan approved by MDHHS, and the Contractor must indicate when and with which community partners the Report was shared. Once reviewed by MDHHS, the Report will be posted on MDHHS' website.

7. Community Engagement

The Contractor must engage community partners or coalitions in each of the Regions they are contracted to serve on how to invest their Community Reinvestment Obligation.

In Regions where they exist, the Contractor must fulfill this requirement by engaging the Michigan Department of Health and Human Services designated SDOH Hub Pilot sites. In Regions with multiple SDOH Hub Pilot sites, the Contractor must engage with all SDOH Hub Pilot sites in a Region that are willing and have capacity to engage with the Contractor.

In Regions that do not have SDOH Hub Pilot sites, the Contractor must fulfill this requirement by engaging community partners or coalitions that:

- Represent multiple sectors;
- Include individuals who live in the community; and
- Focus on priorities identified by the community.

The Contractor must engage with external community coalitions, when available, rather than developing a separate entity to meet this requirement or using a Contractor-specific committee. If SDOH Hub Pilot sites are unavailable in a Region or do not have capacity to engage with the Contractor to fulfill this requirement, appropriate coalitions could include, but are not limited to, Community Health Innovation Regions and Regional Health Equity Councils.

The Contractor must engage with its community partners or coalitions at least three times each year throughout the development of the Community Reinvestment Spending Plan and publication of the Community Reinvestment Expenditures Report, including but not limited to:

- Prior to the development of the Community Reinvestment Spending Plan, so community partners can provide input on potential CBOs and activities to fund.
- Once the Community Reinvestment Spending Plan has been drafted but prior to submission to MDHHS, so community partners can provide input on the draft Plan.
- Once the Community Reinvestment Expenditures Report has been drafted, so the community knows how the funds were invested.

Community engagement must be documented in the appropriate section of the Plan.

8. Example of Community Reinvestment Reporting Cadence

The following table consolidates reporting deadlines for profit accrued in the first contract year (October 1, 2024 – September 30, 2025). Future contract years will follow a similar reporting structure and cadence.

Deliverable	Submission Date	What it Covers	Covered Period
Estimate of Community Reinvestment Obligation	11/15/2025	An initial estimate of the amount of the Community Reinvestment Obligation.	10/1/2024 – 9/30/2025
Community Reinvestment Spending Plan	12/1/2025	How the Community Reinvestment Obligation will be spent over the Investment Period. Investment Period length differs based on the amount of the Community Reinvestment Obligation.	10/1/2025 – 9/30/2026 (1-year Investment Period) OR 10/1/2025 – 9/30/2027 (2-year Investment Period)
MLR Template	4/30/2026	Financial information required for MDHHS to confirm the Community Reinvestment Obligation.	10/1/2024 – 9/30/2025
Community Reinvestment Expenditures Report	4/30/2027	Any investments toward the Community Reinvestment Obligation. • If the Contractor has a one-year Investment Period, this report covers all expenditures for the Community Reinvestment Obligation.	10/1/2025 – 9/30/2026

Deliverable	Submission Date	What it Covers	Covered Period
Estimate of Community Reinvestment Obligation	11/15/2025	An initial estimate of the amount of the Community Reinvestment Obligation.	10/1/2024 – 9/30/2025
Community Reinvestment Spending Plan	12/1/2025	How the Community Reinvestment Obligation will be spent over the Investment Period. Investment Period length differs based on the amount of the Community Reinvestment Obligation.	10/1/2025 – 9/30/2026 (1-year Investment Period) OR 10/1/2025 – 9/30/2027 (2-year Investment Period)
MLR Template	4/30/2026	Financial information required for MDHHS to confirm the Community Reinvestment Obligation.	10/1/2024 – 9/30/2025
		• If the Contractor has a two-year Investment Period, this report covers expenditures for the first year of the two-year Investment Period.	
Community Reinvestment Expenditures Report	4/30/2028	Any investments toward the Community Reinvestment Obligation. • Not applicable if the Contractor has a one-year Investment Period. • If the Contractor has a two-year Investment Period, this report covers expenditures for the second year of the two-year Investment Period.	10/1/2026 – 9/30/2027

9. Monitoring and Compliance

MDHHS will review Community Reinvestment Expenditures Reports to verify that the amount reinvested in communities is at least five percent of pre-tax profit, expended over the designated Investment Period and consistent with the requirements described in this Appendix and Section 4.1.VII. If the Contractor is found to be non-compliant with the requirements, MDHHS may pursue contractual remedies as described in Section 1.1.XX and Appendix 18.

In the event the Contractor terminates this contract, has its contract terminated by MDHHS, or its contract ends prior to its Community Reinvestment Obligation being spent down as required under this contract, the remaining Community Reinvestment Obligation must be invested in accordance with the timeframes outlined in this Appendix.

APPENDIX 13: RESERVED

APPENDIX 14: TRANSITION OF CARE POLICY

Transition of Care

PURPOSE

This appendix specifies requirements on Medicaid Health Plans (MHPs) to ensure continued access to services for Enrollees whose health would be jeopardized if services were disrupted or stopped during a transition from Fee-for-Service (FFS) to an MHP, from one MHP to another, or from some other coverage program (e.g., PIHP, PAHP) to an MHP. Hereinafter, MHP will be referred to as "Contractor."

When developing and executing its transition of care policy, the Contractor must consider the impact of an Enrollee losing access to established providers on the Enrollee's health and wellbeing and shall exercise clinical expertise and commitment to Enrollees' best possible health outcomes at all times.

REQUIREMENTS

The Contractor must develop and execute a transition of care policy to ensure Enrollees have continued access to medically necessary services, as specified in federal and State regulations. The Contractor's transition of care policy and procedures must meet federal transition of care requirements defined at 42 CFR 438.62 and 457.1216. The Contractor's transition of care policy must comply with requirements that include but are not limited to the following.

1. Public Availability

The Contractor must make its transition of care policy publicly available, including on the Contractor's website and in its member handbook, in accordance with 42 CFR 438.10. The Contractor must provide clear instructions to Enrollees on how to access continued services upon a transition.

2. Communication to Enrollees

The Contractor's transition of care policy must include a communication plan describing how the Contractor will communicate the transition of care policy and process to all Enrollees and providers involved in Enrollee care.

3. Applicability of the Policy

The transition of care policy is applicable to Enrollees that would suffer serious detriment to their health or be at risk of hospitalization or institutionalization in the absence of continued access to services during a transition. Continued access to services, or continuity of care, refers to the Enrollee having access to services consistent with the access they previously had and being able to retain their current or prior provider for a period of time, even if that provider is not the Contractor's network.

The Contractor shall ensure continuity of care for all applicable Enrollees. Contractor must include in its transition of care policy specific policies and procedures for Enrollees who, at the time of their Enrollment with the Contractor, have significant health care needs or complex medical conditions or are receiving ongoing services, such as dialysis, home health services, chemotherapy, and radiation therapy. For Enrollees in CSHCS, CSHCS transition requirements shall supersede in the event transition requirements conflict.

4. Continued Access to Providers

The Contractor's transition of care policy must apply to an Enrollee's primary care provider(s), specialist(s), clinic(s) and dentist(s), where the Enrollee has an existing or prior relationship with the provider. A relationship is deemed to exist in the following circumstances:

- **Primary Care Provider:** The Enrollee has seen the primary care provider at least once within the six months prior to enrollment with the Contractor for a non-emergency visit.
- **Specialists:** The Enrollee has seen the specialist at least once within the twelve months prior to enrollment with the Contractor for a non-emergency visit.
- **Other Providers:** The Enrollee has received services from other providers within the six months prior to enrollment with the Contractor. The Contractor must review these services and determine whether continued access to them is necessary to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

If the Contractor cannot determine whether an Enrollee-provider relationship exists based on the available data, the Contractor must ask the provider and Enrollee to provide documentation of the visit(s) from the medical record or proof of payment to establish the relationship.

5. Enrollee-Initiated Requests for Continuity of Care

The Contractor must ensure that the Enrollee, their representative, or the Enrollee's provider is able to request continued access to services during a transition on the Enrollee's behalf. The Contractor must allow such requests to be made verbally or in writing by, at a minimum, contacting the Contractor's member services department or contacting the Enrollee's care coordinator or care manager.

6. Responding to Continuity of Care Requests

The Contractor must make a good faith effort to assess the Enrollee's current and historic medical, dental, mental health, and social needs *as soon as possible*. The Contractor must respond to any request for continuity of care within three business days.

The Contractor must make a good faith effort to assess the Enrollee's current and historic medical, dental, mental health, and social needs *as soon as possible*. The Contractor must respond to any request for continuity of care within three business days.

If the Contractor determines that the transition of care policy applies to an Enrollee (per #2, above), the Contractor must provide continued access to services consistent with the access the Enrollee previously had and permit the Enrollee to retain their current/prior provider for the timeframe specified below, even if that provider is not in the Contractor's network. The Contractor should begin the ongoing monitoring of progress and care planning for the Enrollee to ensure care is not inappropriately interrupted.

The Contractor must honor any prior authorization issued by the prior payer or under the prior coverage program for the timeframe specified below. In the event the Enrollee's needs change and warrant a change in service, the Contractor may conduct a medical necessity review for previously authorized services. Any medical necessity review must reflect the following.

- The service meets generally accepted standards of medical practice;
- The service is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
- The service is appropriate to the health condition for which it is provided and is expected to produce the desired outcome;
- The service provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- The service is not provided primarily for the economic benefit or convenience of anyone other than the recipient.

7. Minimum Timeframes for Continuity of Care

For primary care providers, specialists, and other covered providers:

- The Contractor must maintain current providers and level of services at the time of enrollment **for at least 90 days** from enrollment with the Contractor.
- The Contractor must honor existing prior authorizations **for at least 90 days** from enrollment with the Contractor.
- The Contractor must honor scheduled surgeries, dialysis, chemotherapy and radiation, organ, bone marrow and hematopoietic stem cell transplants.
- For certain services, such as custom-fabricated and non-custom fabricated medical equipment and transportation and CSHCS services, coverage should be based on MDHHS policy specified in this Contract and/or the Medicaid Provider Manual.

These timeframes are the minimum required; the Contractor may extend these timeframes at its discretion. During the continuity of care period, the Contractor must assist the Enrollee with selecting a network provider(s), ensuring referral to an appropriate provider(s) of services following the end of the continuity of care period.

With respect to prescriptions, if the Enrollee received a 30-day supply or more of a prescription drug within the 90 days prior to enrollment with the Contractor, or if access to the prescription drug is necessary to prevent serious detriment to the Enrollee's health, the Contractor must ensure access to the prescription drug without prior authorization. This is required even if:

- The drug is not otherwise covered by the Contractor;
- The Contractor's rules do not cover the amount ordered by the prescriber;
- The drug generally requires prior authorization by the Contractor; or
- The drug is part of a step therapy restriction.

The Contractor's transition of care processes for prescribed drugs shall be consistent with the requirements in Medicare Part D transition guidelines.

8. Interdisciplinary Transition of Care Team

The Contractor must have an Interdisciplinary Transition of Care (ITC) team to implement the transition of care policy and provide oversight and manage all transition processes. The team must include, at a minimum a licensed clinical nurse(s) or physician(s) and requisite staff that support Enrollees access to care during transition.

9. Maintenance and Exchange of Information

The Contractor is required to maintain a record of all authorization requests, including standard and expedited authorization requests and any extension of request granted. Contractor must maintain Enrollee-identifying information (Medicaid ID), request type (standard or expedited), date of original request, extension request, service code, diagnosis code, decision, date of decision, date the Enrollee notice was sent, and if denied, the reason for denial.

The Contractor must ensure that its transition of care policy includes:

- Policies and procedures to request and obtain utilization data from the State or the prior MHP, PAHP, or PIHP and share that information, including medical records, with the new provider(s) serving the Enrollee, as applicable and in compliance with federal and state law.
  A process for the electronic exchange of data in accordance with 42 CFR 438.62(b)(1)(vi).

APPENDIX 15: NETWORK ADEQUACY STANDARDS – TIME AND DISTANCE AND RATIO STANDARDS

Provider Network Adequacy Standards											
	Large Metro		Metro		Micro		Rural		Counties with Extreme Access Considerations		All
	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	Minimum Provider: Enrollees Ratio
Primary Care – Adult*	10	5	15	10	30	20	40	30	70	60	1:500**
Primary Care – Pediatric*	10	5	15	10	30	20	40	30	70	60	1:500**
Hospital*	20	10	30	30	30	30	60	60	110	100	
Gynecology, OB/GYN*	10	5	15	10	30	20	40	30	70	60	
Cardiology	20	10	30	30	30	30	60	60	95	85	
Neurology	20	10	30	30	30	30	60	60	110	100	
Oncology – Medical, Surgical	20	10	30	30	30	30	60	60	110	100	
Oncology – Radiation	30	15	60	40	100	75	110	90	145	130	
Orthopedics/Orthopedic Surgery	20	10	30	30	30	30	60	60	95	85	
Occupational Therapy	20	10	45	30	80	60	75	60	110	100	
Physical Therapy	20	10	45	30	80	60	75	60	110	100	
Speech Therapy	20	10	45	30	80	60	75	60	110	100	
Outpatient Clinical Mental Health (Licensed, Accredited, or Certified Professionals) – Adult***	10	5	15	10	30	20	40	30	70	60	

Outpatient Clinical Mental Health (Licensed, Accredited, or Certified Professionals) – Pediatric***	10	5	15	10	30	20	40	30	70	60	
Psychiatry (including Psychiatrists, Psychiatric/ Mental Health Nurse Practitioners) – Adult***	20	10	45	30	60	45	75	60	110	100	
Psychiatry (including Psychiatrists, Psychiatric/ Mental Health Nurse Practitioners) – Pediatric***	20	10	45	30	60	45	75	60	110	100	
Dentistry: General Dentist	30	15	30	30	30	30	40	40	120	120	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
Dentistry: Endodontics	30	15	60	60	60	60	120	120	120	120	
Dentistry: Oral Surgery	30	15	60	60	60	60	120	120	120	120	
Dentistry: Periodontics	30	15	60	60	60	60	120	120	120	120	
Dentistry: Prosthodontics	30	15	60	60	60	60	120	120	120	120	
Pharmacy	10	5	15	10	30	20	40	30	40	30	
To be counted in the Primary Care Provider (PCP) or General Dentistry ratio calculation, a provider must be enrolled in Medicaid and must be at least full-time (i.e., minimum of 20 hours per week per practice location).											

*Must have minimum of **2 providers** within the time/distance standards in the **Large Metro** and **Metro** counties.

**Except when standard cannot be met because a geographic area does not have sufficient PCPs to meet this standard.

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

Provider Network Exceptions

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

a) For adult and pediatric PCPs, gynecologists and OB/GYNs, specialists, mental health providers, and other non-hospital providers listed in the standards above:

   i) Whether the availability of providers in the service area is limited in number and type, especially in areas designated as Health Professional Shortage Areas.
   ii) The geographic designation of the service area (e.g., the extent to which the service area is rural).
   iii) Whether telehealth services are available in the identified specialty.
   iv) The service delivery pattern of the service area.
   v) Payment rates offered by the Contractor to the identified specialty/provider type.

b) For hospitals:

   i) The availability of hospitals located within the service area.
   ii) The Contractor's ability to contract with hospitals located within the Contractor's service area.
   iii) Payment rates offered by the Contractor to hospitals located within the Contractor's service area.

The following county designation were captured from the “2024 HSD Reference File” found on the cms.gov website and will be updated as new updates are available.

County Designation	County			
Large Metro	Macomb	Oakland	Wayne	
Metro	Allegan	Genesee	Lapeer	St. Clair
	Barry	Grand Traverse	Lenawee	St. Joseph
	Bay	Ingham	Livingston	Shiawassee
	Berrien	Ionia	Midland	Van Buren
	Calhoun	Isabella	Monroe	Washtenaw
	Cass	Jackson	Muskegon	
	Clinton	Kalamazoo	Ottawa	
	Eaton	Kent	Saginaw	
Micro	Alpena	Clare	Leelanau	Newaygo
	Antrim	Emmet	Marquette	Oceana
	Benzie	Gladwin	Mason	Tuscola
	Branch	Gratiot	Mecosta	Wexford
	Charlevoix	Hillsdale	Montcalm	
Rural	Alcona	Gogebic	Manistee	Otsego
	Arenac	Houghton	Menominee	Presque Isle
	Cheboygan	Huron	Missaukee	Roscommon
	Chippewa	Iosco	Montmorency	Sanilac
	Crawford	Kalkaska	Ogemaw	
	Delta	Lake	Osceola	
	Dickinson	Mackinac	Oscoda	
CEAC (Counties with Extreme Access Considerations)	Alger	Iron	Luce	Schoolcraft
	Baraga	Keweenaw	Ontonagon	

APPENDIX 16: NETWORK ADEQUACY STANDARDS – TIMELY ACCESS STANDARDS

Timely Access Standards	
Type of Care / Appointment	**Length of Time**
Emergency Services	Immediately, 24 hours per day 7 days per week
Urgent Care	Within 48 hours
Routine Care	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
Specialty Care	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request
Mental Health*	Routine care within 10 business days of request
	Non-life-threatening emergency within 6 hours of request
	Urgent care with 48 hours of request
Prenatal Care – Initial Prenatal Appointment**	If enrollee is in first or second trimester: Within 7 business days of enrollee being identified as pregnant
	If enrollee is in third trimester: Within 3 business days of enrollee being identified as pregnant
	If there is any indication of the pregnancy being high risk (regardless of trimester): Within 3 business days

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

**Appointment should be with Obstetrician, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training, and demonstrated competence in prenatal care.

Dental Timely Access Standards	
Type of Care / Appointment	**Length of Time**
Emergency Dental Services	Immediately, 24 hours per day 7 days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within 21 business days of request
Preventive Dental Services	Within 6 weeks of request
Initial Dental Appointment	Within 8 weeks of request

APPENDIX 17: PROVIDER DIRECTORY LISTING REQUIREMENTS

Provider Directory Listing Requirements	**Requirements by Provider Type**					
Directory must give enrollees the option to search Medicaid providers by county	**Health Professionals (PCPs & Specialists)**	**Hospitals**	**Pharmacies**	**Facilities**	**Medical Suppliers and Other Ancillary Health Providers**	**NEMT**
Name	Provider Name	Hospital Name	Pharmacy Name	Facility Name	Health Provider Name	NEMT Provider Name
Address	Yes	Yes	Yes	Yes	Yes	Optional
Telephone Number	Yes	Yes	Yes	Yes	Yes	Yes
Website URL (as applicable)	Yes	Yes	Yes	Yes	Yes	Yes
Cultural and Linguistic Capabilities (including American Sign Language)	Yes	Yes	Yes	Yes		Yes
Whether provider's office accommodates persons with physical disabilities (including offices and exam rooms)	Yes	Yes	Yes	Yes		Yes
Whether accepting children and youth with chronic health conditions, including CSHCS Enrollees	Yes					
Whether accepting young adults with chronic health conditions, including CSHCS Enrollees	Yes					
Specialty(s)	Specialty(s)	Hospital Type		Facility Type		
Board Certification	Yes	Hospital Accreditation				
Additional office locations (as applicable)	Yes					
Gender	Yes					
Medical Group affiliation (as applicable)	Yes					
Office Hours	Yes					Yes
Whether accepting new patients (include any restrictions)	Yes					

Languages spoken other than English	Yes					Yes
Whether the provider has completed cultural competency training	Yes					
Whether the provider is enrolled in Vaccines for Children (VFC) program	Yes					
Whether provider offers telehealth (Effective 7/1/2025)	Yes					

APPENDIX 18: LIQUIDATED DAMAGES AND MONETARY SANCTIONS

Liquidated Damages and Monetary Sanctions		
#	FINDING	MONETARY SANCTION
1	**Failure to Comply with Encounter Data Submission Requirements:** Contractor failure to comply with encounter data submission requirements as described in this Contract -(Section 3.2, II.D.; Appendix 3)	**$25,000** per occurrence.
2	**Failure to Comply with Encounter Data Correction Requirements:** Contractor failure to comply with timely encounter data correction requirements as described in this Contract. (Section 3.2., II.D.))	**$5,000** per day, per occurrence.
3	**Failure to Address MDHHS-OIG Identified Encounter Issues:** Contractor failure to address or resolve, in a timely manner, errors with individual encounter records identified by MDHHS-OIG review of Contractor's quarterly reports submitted pursuant to ⁄Section 1.1., XIX., B.1).	**$500** per day, per identified encounter
4	**Failure to Submit Compliance Review Materials:** Contractor failure to submit all reports required by this Contract for Contract Compliance Review by the due date specified by MDHHS (Section 3.2, II.B).	**$1,000** per day per occurrence
5	**Late Submission of Information to MDHHS-OIG:** Contractor failure to submit a deliverable for MDHHS-OIG provider referral or member referral request by the due date (Section 1.1., XIX)	**$500** per day per occurrence
6	**Late Submission of Initial CAP:** Contractor failure to submit, by the specified due date, a CAP as prescribed by MDHHS (Section 1.1, XX, B.11).	**$1,000** per calendar day for each day CAP is late
7	**Failure to Provide Acceptable Initial Corrective Action Plan (CAP):** Contractor failure to provide a complete and acceptable CAP as prescribed by MDHHS by the specified due date (Section 1.1, XX., B.11).	**$5,000 per occurrence**
8	**Non-Compliance with Accepted CAP:** Contractor failure to comply with an accepted CAP as required by MDHHS (Section 1.1, XX, B.11).	**$2,500** per calendar day for each day the Contractor fails to comply
9	**Non-Compliance with Key Contract Requirements:** Contractor failure to comply with the Contract requirements, including but not limited to: a. Marketing practices b. Member services c. Provision of Medically Necessary, Covered Services d. Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services. e. Provider Networks f. Provider payments	The determination of the amount of any monetary sanction shall be at the sole discretion of MDHHS, within ranges set by MDHHS. Self-reporting by Contractor will be taken into consideration in determining the amount of the monetary sanction.

	g. Financial requirements including but not limited to failure to comply with Physician Incentive Plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program. h. Enrollee satisfaction i. Healthy Behavior policy and operational process j. Performance standards included in Appendix 4 to the Contract. k. Misrepresentation or false information provided to MDHHS, CMS, Providers, Enrollees, or Potential Enrollees l. URAC or NCQA accreditation m. Certificate of Authority n. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations o. Community reinvestment (Section 1.1, XX, A.4)	
10	**Repeated Failure to Comply with the Contract:** Repeated failure of the Contractor to meet the requirements of this Contract. (Section 1.1, XX, A.7).	The determination of the amount of any monetary sanction shall be at the sole discretion of MDHHS, within ranges set by MDHHS.
11	**Federal Intermediate Sanctions:** Contractor failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with physician incentive plan requirements; or Marketing violations. (Section 1.1, XX, A.5)	A maximum of **$25,000** for each determination of failure
12	**Federal Intermediate Sanctions:** Determination of Contractor discrimination, or Contractor misrepresentation or false statements to CMS or the State. (Section 1.1, XX, A.5)	A maximum of **$100,000** for each determination
13	**Federal Intermediate Sanctions:** Contractor failure to enroll recipients because of a discriminatory practice (subject to the $100,000 overall limit above). (Section 1.1, XX, A.5)	A maximum of **$15,000** for each recipient
14	**Federal Intermediate Sanctions:** Contractor charge of copayments in excess of the amounts permitted under the Medicaid program. Note: MDHHS will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s). (Section 1.1, XX, A.5)	A maximum of **$25,000** or double the amount of the excess charges, whichever is greater

APPENDIX 19: CONTRACT COMPLIANCE REVIEW – PROGRAM INTEGRITY

Report Reference	Due Date	Period Covered
Annual Submissions		
Annual Program Integrity Report for Michigan Medicaid	January 15	Previous Fiscal Year Current Fiscal Year Next Fiscal Year
Compliance Program	March 15	Contractor policies and procedures in place and/or revised in: Previous Fiscal Year Current Fiscal Year
Quarterly Submissions (previous months reporting)		
Quarterly EOB Log	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Data Mining/Algorithm Log	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Tips and Grievances Log	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Overpayments Identified Reporting Form	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Recoveries Reporting Form	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Fraud Referral Log	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Provider Disenrollment Log (Associated with Activities)	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30

Quarterly Provider Prepayment Review Placement Log (Associated with Activities)	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Encounter Adjustment Submission	February 15 May 15 August 15 November 15	October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30
Quarterly Encounter Validation Report (Run by MDHHS-OIG on encounter adjustments submitted quarterly by Contractor.)	MDHHS-OIG validation of submitted encounter adjustments: January 15 April 15 July 15 October 15	July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30
On Request, or while Onsite		
Records	Within three Business Days from the date of the request unless otherwise specified by MDHHS OIG.	
Ad HOC		
Fraud Referral Form	Within five Business Days from the date of determining a credible allegation of fraud exists.	
Provider Adverse Action and Exclusion Reporting Form	Within 20 Business Days of any adverse actions taken by the Contractor.	

APPENDIX 20: ILOS POLICY GUIDE

Contractor must utilize the Michigan In Lieu of Services Guide located in the link below:

202409-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf

This guide is a resource for Medicaid Health Plans participating in the Comprehensive Health Care Program in the implementation of ILOS. The Policy Guide provides a comprehensive overview of ILOS as well as additional operational requirements and guidance to support MHPs in delivering ILOS.

APPENDIX 21: ELECTRONIC FILE DESCRIPTION

Electronic File Description – Medicaid Health Plans

Files transferred via MDHHS File Transfer Service

File Name	File Number	Description	Sending Organization	Receiving Organization	Frequency[1]
MHP Provider File	4275	Proprietary fixed field file to submit details of provider network for use by Department's Enrollment Broker	Contractor	MDHHS Enrollment Broker	Weekly; minimum monthly
ETRR Encounter Error Response File	4950	HIPAA transaction that reflects errors in the 5476 individual Encounter transactions submitted by the Contractor	Department CHAMPS	Contractor	Daily; response file
834 Audit File	4976	HIPAA transaction that reflects its Enrollees for the following calendar month.	Department CHAMPS	Contractor	Monthly
820 Payment File	4985	HIPAA transaction that identifies each Enrollee for whom payment was made by the Department to Contractor.	Department CHAMPS	Contractor	Weekly
Daily Carve-Out Utilization File	5165	Proprietary fixed field file with Enrollee-specific utilization information for pharmacy claims in the MDHHS Data Warehouse for medication that is carved out of this Contract.	MDHHS Health Services Data Warehouse	Contractor	Daily
PCP Submission File	5284	Proprietary fixed field file used to submit additions and changes to the PCP assignment of Enrollees to the Department	Contractor	Department	Weekly; minimum monthly
837D Encounter File	5476	HIPAA transaction that identifies healthcare claims for dental claims or Encounters.	Contractor	Department	Daily; minimum monthly
837I Encounter File	5476	HIPAA transaction that identifies healthcare claims for institutional claims and Encounters.	Contractor	Department	Daily; minimum monthly
837P Encounter File	5476	HIPAA transaction that identifies healthcare claims for professional claims and Encounters	Contractor	Department	Daily; minimum monthly
CSHCS Medical Review Date Report (Renewal Report)	5623	The Medical Review Date Report displays a list of all MHP enrollee clients with CSHCS enrollment ending after the current system date for a specific MHP provider.	Department CSHCS	Contractor	Monthly
CSHCS Medical Eligibility Decisions Report	5624	The CSHCS Medical Eligibility Decisions Report displays a list of all MHP enrollee clients with a CSHCS medical eligibility decision for medical records received during the past month	Department CSHCS	Contractor	Monthly
Integrated Care Data Request	5656	Proprietary text file containing the Member IDs of Enrollees for which integrated care information is requested	Contractor	MDHHS Data Warehouse (DCHBULLB)	On Demand

File Name	File Number	Description	Sending Organization	Receiving Organization	Frequency[1]
Integrated Care Data Request Response	5657	Binary zipped file containing the claim and encounter data for the requested Contractor Enrollees.	MDHHS Data Warehouse (DCHBULLB)	Contractor	On Demand
HMP Healthy Behaviors Error File	5725	Proprietary fixed field file that transmits file layout and data specification errors from the Contractor's previous HMP Healthy Behavior File (5944)	Department CHAMPS	Contractor	Daily
PCP Submission Error Response File	5785	Proprietary fixed field file that transmits file layout and data specification errors from the Contractor's previous PCP assignment of Enrollees File (5284)	Department CHAMPS	Contractor	Daily
834 Daily File	5790	HIPAA transaction that reflects changes in enrollment after the previous 834 Audit File.	Department CHAMPS	Contractor	Daily
Enrolled Providers File	5938	Extract from CHAMPS provider enrollment containing information on providers enrolled in CHAMPS	Department CHAMPS	Contractor	Weekly
TPL Coverage File	6006	Proprietary piped-delimited file sent to the Contractor via the MDHHS/contractor established FTS setup. The file provides a full three years of commercial eligibility history and all Medicare eligibility history for members enrolled within that Contractor's plan. The Contractor must utilize this information to pursue other sources of payment that should be used prior to Medicaid funds. The layout for this file can be found in the appendix of the TPL Guidelines for Managed Care Plans. All questions regarding this file or data shared on this file should be directed to MDHHS-TPL-MANAGEDCARE@michigan.gov.	Department TPL	Contractor	Daily

[1] Frequency refers to how often the file is scheduled to be created/transferred. Some files may be sent at various intervals and the frequency refers to how often the system will accept the file.

APPENDIX 22: CAPITATION RATE CERTIFICATION

Medicaid Health Plan Capitation Rate Certification

The Medicaid per member per month rates effective October 1, 2024 are located in the link below.

SFY 2025 Medicaid Managed Care Certification (michigan.gov)