STATE OF MICHIGAN

Contract No.
Healthy Kids Dental Program

Contents

STATE OF MICHIGAN

Standard Contract Terms

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and ("**Contractor**"). This Contract is effective April 1, 2018 ("**Effective Date**"), and unless terminated, expires on September 30, 2025. The Transitional Implementation Period will be the time period between the Contract Effective Date and the Services Begin Date on October 1, 2018. Contractor must commence performance of all Services, without interruption, on October 1, 2018.

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

The parties agree as follows:

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

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

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

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

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

If to State:	If to Contractor:

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

State:	Contractor:

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 (day to day) *Michigan Department of Health and Human Services* *Capitol Commons Center* *400 S. Pine, Lansing, MI 48933* *therrienj1@michigan.gov* *Phone (517) 284-1145*	

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

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

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence Limit $1,000,000 Personal & Advertising Injury Limit $2,000,000 General Aggregate Limit $2,000,000 Products/Completed Operations	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. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Umbrella or Excess Liability Insurance	

Minimal Limits: $5,000,000 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.
Automobile Liability Insurance	
Minimal Limits: If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	Contractor must have their policy include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease.	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $20,000,000 Each Occurrence $20,000,000 Annual Aggregate	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime (Fidelity) Insurance	
Minimal Limits: $5,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add “the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents” as Loss Payees as their interests may appear.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $10,000,000 Each Occurrence $10,000,000 Annual Aggregate	

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

Insurance Type	Additional Requirements

Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 0. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Automobile Liability Insurance	
Minimal Limits: If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	Contractor must have their policy include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime (Fidelity) Insurance	
Minimal Limits: $1,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees as their interests may appear.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits:	

$1,000,000 Each Occurrence $3,000,000 Annual Aggregate	

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

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Per Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 04. Coverage must not have exclusions or limitations related to sexual abuse and molestation liability.
Automobile Liability Insurance	
Minimal Limits: If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	Contractor must have their policy include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $1,000,000 Each Occurrence $3,000,000 Annual Aggregate	

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

Required Limits	Additional Requirements
Medical Malpractice Liability Insurance	
Minimal Limits: $200,000 Each Occurrence $600,000 Annual Aggregate Deductible Maximum: $5,000 Each Occurrence	

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

Contractor must: (a) provide insurance certificates to the Contract Administrator, containing the agreement or purchase order number, at Contract formation and within 20 calendar days of the expiration date of the applicable policies; (b) require that subcontractors maintain the required insurances contained in this Section; (c) notify the Contract Administrator within five business days if any insurance is cancelled; and (d) waive all rights against the State for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

This Section is not intended to and is not 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 hereofrequiring Contractor to indemnify, defend and hold harmless the State).

7. **Reserved.**

8. **Reserved.**

9. **Independent Contractor.** Contractor is an independent contractor and assumes all rights, obligations and liabilities set forth in this Contract. Contractor, its employees, and agents will not be considered employees of the State. No partnership or joint venture relationship is created by virtue of this Contract. Contractor, and not the State, is responsible for the payment of wages, benefits and taxes of Contractor's employees and any subcontractors. Prior performance does not modify Contractor's status as an independent contractor.

   Contractor hereby acknowledges that the State is and will be the sole and exclusive owner of all right, title, and interest in the Contract Activities and all associated intellectual property rights, if any. Such Contract Activities are works made for hire as defined in Section 101 of the Copyright Act of 1976. To the extent any Contract Activities and related intellectual property do not qualify as works made for hire under the Copyright Act, Contractor will, and hereby does, immediately on its creation, assign, transfer and otherwise convey to the State, irrevocably and in perpetuity, throughout the universe, all right, title and interest in and to the Contract Activities, including all intellectual property rights therein.

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

Activities, compliance with the terms of this Contract, and the acts and omissions of the subcontractor. The State, in its sole discretion, may require the replacement of any subcontractor.

Under this Contract, there are two classifications of Subcontractors:

Category I: Administrative Subcontractors

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

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

Category II: Provider (Network Provider)

An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any Subcontractor, for the delivery of Covered Services to Enrollee.

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

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

12. **Background Checks.** Upon request, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

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

14. **Change of Control.** Contractor will notify, at least 90 calendar days before the effective date, the State of a change in Contractor's organizational structure or ownership. For purposes of this Contract, a change in control means any of the following: (a) a sale of more than 50% of Contractor's stock; (b) a sale of substantially all of Contractor's assets; (c) a change in a majority of Contractor's board members; (d) consummation of a merger or consolidation of Contractor with any other entity; (e) a change in ownership through a transaction or series of transactions; (f) or the board (or the stockholders) approves a plan of complete liquidation. A change of control does not include any consolidation or merger effected exclusively to change the domicile of Contractor, or any transaction or series of transactions principally for bona fide equity financing purposes.

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

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

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

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

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

17. **Reserved.**

18. **Reserved.**

19. **Reserved.**

20. **Terms of Payment.** Invoices must conform to the requirements communicated from time-to-time by the State. All undisputed amounts are payable within 45 days of the State's receipt. Contractor may only charge for Contract Activities performed as specified in Schedule A. Invoices must include an itemized statement of all charges. The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use.

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

    The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor must register with the State at http://www.michigan.gov/cpexpress to receive electronic fund transfer payments. If Contractor does not register, the State is not liable for failure to provide payment. Without prejudice to any other right or remedy it may have, the State reserves the right to set off at any time any amount then due and owing to it by Contractor against any amount payable by the State to Contractor under this Contract.

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

A.

22. **Stop Work Order.** The State may suspend any or all activities under the Contract at any time. The State will provide Contractor a written stop work order detailing the suspension. Contractor must comply with the stop work order upon receipt. Within 90 calendar days, or any longer period agreed toby Contractor, the State will either: (a) issue a notice authorizing Contractor to resume work, or (b) terminate the Contract or purchase order. The State will not pay for Contract Activities, Contractor's lost profits, or any additional compensation during a stop work period.

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

    If the State terminates this Contract under this Section, the State will issue a termination notice specifying whether Contractor must: (a) cease performance immediately, or (b) continue to perform for a specified period. If it is later determined that Contractor was not in breach of the Contract, the termination will be deemed to have been a Termination for Convenience, effective as of the same date, and the rights and obligations of the parties will be limited to those provided in Section 24, Termination for Convenience.

    The State will only pay for amounts due to Contractor for Contract Activities accepted by the State on or before the date of termination, subject to the State's right to set off any amounts owed by the Contractor for the State's reasonable costs in terminating this Contract. The Contractor must pay all reasonable costs incurred by the State in terminating this Contract for cause, including administrative costs, attorneys' fees, court costs, transition costs, and any costs the State incurs to procure the Contract Activities from other sources.

24. **Termination for Convenience.** The State may immediately terminate this Contract in whole or in part without penalty and for any reason, including but not limited to, appropriation or budget shortfalls. The termination notice will specify whether Contractor must: (a) cease performance of the Contract Activities immediately, or (b) continue to perform the Contract Activities in accordance with Section 25, Transition Responsibilities. If the State terminates this Contract for convenience, the State will pay all reasonable costs, as determined by the State, for State approved Transition Responsibilities.

25. **Transition Responsibilities.** Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed 365 calendar days), provideall reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees. Such transition assistance may include, but is not limited to: (a) continuing to perform the Contract Activities at the established Contract rates; (b) taking all reasonable and necessary measures to transition performance of the work, including all applicable Contract Activities, training, equipment, software, leases, reports and other documentation, to the State or the State's designee; (c) taking all necessary and appropriate steps, orsuch other action as the State may direct, to preserve, maintain, protect, or return to the State all materials, data, property, and confidential information provided directly or indirectly to Contractor by any entity, agent, vendor, or employee of the State; (d) transferring title in and delivering to the State, at the State's discretion, all completed or partially completed deliverables prepared under this Contract as of the Contract termination date; and (e) preparing an accurate accounting from which the State andContractor may reconcile all outstanding accounts (collectively, "**Transition Responsibilities**"). This Contract will automatically be extended through the end of the transition period.

26. **General Indemnification.** Contractor must defend, indemnify and hold the State, its departments, divisions, agencies, offices, commissions, officers, and employees harmless, without limitation, from

and against any and all actions, claims, losses, liabilities, damages, costs, attorney fees, and expenses (including those required to establish the right to indemnification), arising out of or relating to: (a) any breach by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable) of any of the promises, agreements, representations, warranties, or insurance requirements contained in this Contract; (b) any infringement, misappropriation, or other violation of any intellectual property right or other right of any third party; (c) any bodily injury, death, or damage to real or tangible personal property occurring wholly or in part due to action or inaction by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable); and (d) any acts or omissions of Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable).

The State will notify Contractor in writing if indemnification is sought; however, failure to do so will not relieve Contractor, except to the extent that Contractor is materially prejudiced. Contractor must, to the satisfaction of the State, demonstrate its financial ability to carry out these obligations.

The State is entitled to: (i) regular updates on proceeding status; (ii) participate in the defense of the proceeding; (iii) employ its own counsel; and to (iv) retain control of the defense if the State deems necessary. Contractor will not, without the State's written consent (not to be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any claim, action, or proceeding. To the extent that any State employee, official, or law may be involved or challenged, the State may, at its own expense, control the defense of that portion of the claim.

Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. An attorney designated to represent the State may not do so until approved by the Michigan Attorney General and appointed as a Special Assistant Attorney General.

27. **Infringement Remedies.** If, in either party's opinion, any piece of equipment, software, commodity, or service supplied by Contractor or its subcontractors, or its operation, use or reproduction, is likely to become the subject of a copyright, patent, trademark, or trade secret infringement claim, Contractor must, at its expense: (a) procure for the State the right to continue using the equipment, software, commodity, or service, or if this option is not reasonably available to Contractor, (b) replace or modify the same so that it becomes non-infringing; or (c) accept its return by the State with appropriate credits to the State against Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

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

29. **Disclosure of Litigation, or Other Proceeding.** Contractor must notify the State within 14 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving Contractor, a subcontractor, or an officer or director of Contractor or subcontractor, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Contractor's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

30. **Reserved.**

31. State Data.

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

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

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

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

e. Loss of Data. In the event of any act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise the security, confidentiality, or integrity of State Data or the physical, technical, administrative, or organizational safeguards put in placeby 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 ininvestigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise requiredby the State; (c) in the case of PII or PHI, at the State's sole election, (i) notify the affected individuals who comprise the PII or PHI as soon as practicable but no later than is required tocomply with applicable law, or, in the absence of any legally required notification period, withinfive calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for

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

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

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

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

c. Cooperation to Prevent Disclosure of Confidential Information. Each party must use its best efforts to assist the other party in identifying and preventing any unauthorized use or disclosureof 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 ofthis Contract and each party will cooperate with the other party in seeking injunctive or other equitable relief against any such person.

d. Remedies for Breach of Obligation of Confidentiality. Each party acknowledges that breach of its obligation of confidentiality may give rise to irreparable injury to the other party, which damage may be inadequately compensable in the form of monetary damages. Accordingly, a party may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies which may be available, to include, in the case of the State, at the sole election of the State, the immediate termination, without liability to the State, of this Contract or any Statement of Work corresponding to the breach or threatened breach.

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

33. Data Privacy and Information Security.

a. Undertaking by Contractor. Without limiting Contractor's obligation of confidentiality as further described, Contractor is responsible for establishing and maintaining a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (a) ensure the security and confidentiality of the State Data; (b) protect against any anticipated threats or hazards to the security or integrity of the State Data; (c) protect against unauthorized disclosure, access to, or use of the State Data; (d) ensure the proper disposal of State Data; and (e) ensure that all employees, agents, and subcontractors of Contractor, if any, comply with all of the foregoing. In no case will the safeguards of Contractor's data privacy and information security program be less stringent than the safeguards used by the State, and Contractor must at all times comply with all applicable State IT policies and standards, which are available to Contractor upon request.

b. Audit by Contractor. No less than annually, Contractor must conduct a comprehensive independent third-party audit of its data privacy and information security program and provide such audit findings to the State.

c. Right of Audit by the State. Without limiting any other audit rights of the State, the State has the right to review Contractor's data privacy and information security program prior to the commencement of Contract Activities and from time to time during the term of this Contract. During the providing of the Contract Activities, on an ongoing basis from time to time and without notice, the State, at its own expense, is entitled to perform, or to have performed, an on-site audit of Contractor's data privacy and information security program. In lieu of an on-site audit, upon request by the State, Contractor agrees to complete, within 45 calendar days of receipt, an audit questionnaire provided by the State regarding Contractor's data privacy and information security program.

d. Audit Findings. Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

e. State's Right to Termination for Deficiencies. The State reserves the right, at its sole election, to immediately terminate this Contract or a Statement of Work without limitation and without liability if the State determines that Contractor fails or has failed to meet its obligations under this Section.

34. **Reserved**

35. **Reserved.**

36. **Records Maintenance, Inspection, Examination, and Audit.** The State or its designee may audit Contractor to verify compliance with this Contract. Contractor must retain and provide to the State orits designee and the auditor general upon request, all financial and accounting records related to the Contract through the term of the Contract and for 10 years after the latter of termination, expiration, or final payment under this Contract or any extension ("**Audit Period**"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

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

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

37. **Warranties and Representations.** Contractor represents and warrants: (a) Contractor is the owner or licensee of any Contract Activities that it licenses, sells, or develops and Contractor has the rights necessary to convey title, ownership rights, or licensed use; (b) all Contract Activities are delivered free from any security interest, lien, or encumbrance and will continue in that respect; (c) the Contract Activities will not infringe the patent, trademark, copyright, trade secret, or other proprietary rights of any third party; (d) Contractor must assign or otherwise transfer to the State or its designee any manufacturer's warranty for the Contract Activities; (e) the Contract Activities are merchantable and fit for the specific purposes identified in the Contract; (f) the Contract signatory has the authority to enter into this Contract; (g) all information furnished by Contractor in connection with the Contract 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 23, Termination for Cause.

38. **Conflicts and Ethics.** Contractor will uphold high ethical standards and is prohibited from: (a) holding or acquiring an interest that would conflict with this Contract; (b) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract; (c) attempting to influence or appearing to influence any State employee by the direct or indirect offer of anything of value; or (d) paying or agreeing to pay any person, other than employees and consultants working for Contractor, any consideration contingent upon the award of the Contract. Contractor must immediately notify the State of any violation or potential violation of these standards. This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

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

regulations.

40. **Reserved.**

41. **Reserved.**

42. **Nondiscrimination.** Under the Elliott-Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, *et seq*., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, *et seq*., Contractor andits 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 indirectlyrelated to employment, because of race, color, religion, national origin, age, sex, height, weight, maritalstatus, or mental or physical disability. Breach of this covenant is a material breach of this Contract.

43. **Unfair Labor Practice.** Under MCL 423.324, the State may void any Contract with a Contractor or subcontractor who appears on the Unfair Labor Practice register compiled under MCL 423.322.

44. **Governing Law.** This Contract is governed, construed, and enforced in accordance with Michigan law, excluding choice-of-law principles, and all claims relating to or arising out of this Contract are governed by Michigan law, excluding choice-of-law principles. Any dispute arising from this Contract must be resolved in Michigan Court of Claims. Contractor consents to venue in Ingham County, and waives any objections, such as lack of personal jurisdiction or *forum non conveniens*. Contractor must appoint agents in Michigan to receive service of process.

45. **Non-Exclusivity.** Nothing contained in this Contract is intended nor will be construed as creating any requirements contract with Contractor. This Contract does not restrict the State or its agencies from acquiring similar, equal, or like Contract Activities from other sources.

46. **Force Majeure.** Neither party will be in breach of this Contract because of any failure arising from any disaster or acts of god that are beyond their control and without their fault or negligence. Each party will use commercially reasonable efforts to resume performance. Contractor will not be relieved of a breach or delay caused by its subcontractors. If immediate performance is necessary to ensure public health and safety, the State may immediately contract with a third party.

47. **Dispute Resolution.** The parties will endeavor to resolve any Contract dispute in accordance with this provision. The dispute will be referred to the parties' respective Contract Administrators or Program Managers. Such referral must include a description of the issues and all supporting documentation. The parties must submit the dispute to a senior executive if unable to resolve the dispute within 15 business days. The parties will continue performing while a dispute is being resolved, unless the dispute precludes performance. A dispute involving payment does not preclude performance.

    Litigation to resolve the dispute will not be instituted until after the dispute has been elevated to the parties' senior executive and either concludes that resolution is unlikely or fails to respond within 15 business days. The parties are not prohibited from instituting formal proceedings: (a) to avoid the expiration of statute of limitations period; (b) to preserve a superior position with respect to creditors; or (c) where a party makes a determination that a temporary restraining order or other injunctive reliefis the only adequate remedy. This Section does not limit the State's right to terminate the Contract.

48. **Media Releases.** News releases (including promotional literature and commercial advertisements) pertaining to the Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions of the State.

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

50. **Entire Agreement and Order of Precedence.** This Contract, which includes Schedule A – Statement of Work, and expressly incorporated schedules and exhibits, is the entire agreement of the parties

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

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

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

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

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

Federal Provisions Addendum

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

1. Reserved.

2. Reserved.

3. Copeland "Anti-Kickback" Act

If applicable, the Contractor must comply with the Copeland "Anti-Kickback" Act (40 USC 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"), which prohibits the Contractor and subrecipients from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled

4. Reserved.

5. Rights to Inventions Made Under a Contract or Agreement.

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

6. Clean Air Act.

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

7. Debarment and Suspension.

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

8. Byrd Anti-Lobbying Amendment.

If this Contract **exceeds $100,000**, bidders and the Contractor must file the certification required under 31USC 1352.

9. Procurement of Recovered Materials.

Under 2 CFR 200.322, a non-Federal entity that is a state agency or agency of a political subdivision of astate **and its contractors** must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded.

$10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

STATE OF MICHIGAN

Contract No.

Healthy Kids Dental Program (HKD)

SCHEDULE A

STATEMENT OF WORK

CONTRACT ACTIVITIES

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

PROJECT REQUEST

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

DEFINITIONS

Contract definitions are provided in Appendix S.

BACKGROUND

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

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

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

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

1. Address and overcome dental obstacles for the enrolled HKD population.

2. Increase coordination of physical and oral health for HKD Enrollees.

   Oral Health in Michigan

   In April 2015, the Center for Health Workforce Studies (CHWS), School of Public Health, University at Albany, State University of New York, published the Oral Health in Michigan Report1. In its report, CHWS concluded that Michigan has made significant strides in expanding dental care access and improved oral health outcomes for its residents through Michigan's innovation and collaborative efforts. The report also concluded Michigan has a number of remaining challenges in its continuing

[1] School of Public Health, University of Albany, State University of New York. Oral Health in Michigan, https://www.chwsny.org/wp-content/uploads/2015/06/Oral_Health_MI_Report_Final_reduced.pdf

efforts to improve oral health. These challenges include:

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

In 2016, MDHHS, in Collaboration with the Michigan Oral Health Coalition and input of various stakeholders, developed the 2020 Michigan State Oral Health Plan (MSOHP)[2]. In 2021, this collaboration reconvened to develop the 2025 Michigan State Oral Health Plan (MSOHP)[3]. The three plan goals are:

- Michiganders understand the value of daily oral health care and preventative dental care and have the tools to care for their mouth every day.
- Michigan citizens, dental professionals, and medical providers understand the connection between oral health and overall health.
- Michiganders have access to preventative and restorative oral health care because the state has developed the necessary infrastructure to effectively serve everyone.

Similar to the CHWS report, the MSOHP recognized the progress Michigan has made in oral health. The MSOHP noted challenges of Oral Health Disparities among Michigan residents of low socioeconomic status, minority race and ethnicity, pregnant women and Children with Special Needs and disabilities. These disparities negatively impact oral health access, use, knowledge, and outcomes.

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

Though Michigan has made great strides in the HKD program, it is continuously looking to improve oral health outcomes by leveraging its previous program knowledge, engaging community partners, and collaborating with stakeholders to find solutions. Contractor must recognize that Population Health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age), and the distribution of health conditions, health-related behaviors and outcomes including, but not limited to: physical, dental, mental, and social needs among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age).

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

Contract Goals

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

1. Leveraging the HKD model to promote good oral health practices among the HKD population that result in:

[2] Michigan Department of Health and Human Services (MDHHS) and Michigan Oral Health Coalition (MOHC). 2020Michigan State Oral Health Plan http://www.michigan.gov/documents/mdhhs/2020_MichiganStateOralHealthPlan_FINAL_511929_7.pdf, 2016

[3] Michigan Department of Health and Human Services (MDHHS) and Michigan Oral Health Coalition (MOHC). 2025 Michigan State Oral Health Plan Michigan State Oral Health Plan 2025

- increased utilization of preventive Dental Services
- increased oral health education that emphasizes the importance of good oral health and practices.
- decreased dental anxiety.

2. Promoting a patient-centered approach that recognizes the importance of dental care in overall health care and promoting professional integration and coordination of care across provider types.

3. Increasing the number of dental providers participating in the HKD program.

4. Increasing access to oral health care.

5. Designing and implementing best practices for Dental Service delivery in dental care health shortage areas with limited dental providers.

6. Collaborating with community organizations and stakeholders resulting in partnerships that leverage existing dental programs (i.e., school based, dental clinics etc.).

7. Increasing education and Dental Service usage among Enrollees who are pregnant and Children with Special Needs.

SCOPE

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

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

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

1.0 General Requirements

1.1 Contractor Requirements

Contractor must provide Deliverables and staff, and otherwise do all things necessary for or incidental to the requirements and performance of work, pursuant to the requirements set forth in this Contract. Contractor must comply with all provisions of Medicaid Policy applicable to Contractors unless provisions of this Contract stipulate otherwise. All policies, procedures, operational plans, and clinical guidelines followed by the Contractor must be in writing and available to MDHHS and Centers for Medicare and Medicaid Services (CMS) upon request. All dental records, report formats, information systems, liability policies, provider network information and other details specific to performing the contracted services must

be available to MDHHS and CMS upon request.

I. Service Area

A. Service Area

1. Regional Service Area

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

II. Medicaid Eligibility

A. Medicaid Eligibility Determination

1. The HKD benefit program provides dental coverage for individuals 0 through 20 years of age and is funded under both the Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program (CHIP) of the Social Security Act. MDHHS has the sole authority to determine whether individuals meet statutory eligibility requirements and will determine eligibility for enrollment in the HKD benefit program.

2. MDHHS will determine Beneficiary eligibility annually.

3. Contractor must require network providers to verify Enrollee eligibility at time of service delivery.

B. Loss of Medicaid Eligibility During Treatment

1. Contractor must cover services for Enrollees that lose Medicaid or CHIP eligibility while enrolled in the Contractor's dental plan during the course of treatment that require appointments beyond the last day of eligibility, provided the services are completed within 60 days from the date of eligibility loss. The capitation payment made to the Contractor will cover the completion of these services.

III. Covered Services

A. Generally Covered Services

1. Contractor must have available and provide, at a minimum, the appropriate medically necessary covered services defined as services related to the following:

   a. The prevention, diagnosis, and treatment of dental disease

   b. The ability to assess and deliver age-appropriate dental services.

   c. The ability to restore and maintain dental function.

   d. The promotion of good oral health practices to beneficiaries

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

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

4. Contractor must ensure all reporting requirements, quality assurance, and compliance activities required by MDHHS of the Contractor apply equally to all Subcontractors used for the provision of covered services.

B. Dental Services Covered Under this Contract:

1. Contractor must provide or arrange for the provision of the full range of covered dental services as described in this Contract and outlined below and in **Appendix B**, Covered Code of Dental Terminology (CDT) Codes.

2. The Contractor is required to cover, at a minimum, all CDT codes covered by MDHHS Medicaid at a rate not lower than the established Medicaid reimbursement rate. The HKD program utilizes the CDT as the nationally accepted code set. All code definitions set by the CDT apply to Medicaid policy. It is the responsibility of the Contractor to comply with the most current MDHHS policy and code additions and communicate this information to its network providers.

3. Contractor may choose to provide services over and above those specified. Covered dental services provided to Enrollees under this Contract include, but are not limited to, the following:

    a. Emergency and post-stabilization dental services

    b. Diagnostic services

    c. Preventive services

    d. Restorative services

    e. Limited adjunctive services

    f. Endodontic services

    g. Limited crown coverage

    h. Prosthodontics

    i. Removable prosthodontics

    j. Oral surgery services

    k. All medically necessary services

4. Medically Necessary Services

    Contractor's standards for determining medically necessary services must not be more restrictive than standards used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes, regulations, the State Plan, Medicaid Provider Manual and other State policy and procedures. The Contractor must:

    a. Provide all early periodic screening diagnostic and treatment services as required in this Contract.

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

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

d. Provide for the ability for an Enrollee to attain, maintain or regain oral functional capacity.

e. Provide for the opportunity for an Enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice as it relates to oral health.

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

a. The Contractor must provide EPSDT services as medically necessary in accordance with 42 USC Sec. 1396d(r)(3)(5), 42 CFR part 441, Subpart B, and MSA 16-01 (**Appendix M**) whether or not such services are covered under the State Plan and without regard to established limits.

b. Contractor must have a process that provides services to Enrollees for services not covered under the State Plan that have been determined to be medically necessary.

c. The Contractor must provide Enrollees with all covered services in accordance with the Michigan Dental Periodicity Schedule **(Appendix L)** as adopted from the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.

d. Contractor must not have overly burdensome prior authorization requirements for referrals for diagnostic and/or treatment services determined necessary by the Enrollee's dental provider. This includes, but is not limited to:

i. Must make any prior authorization requirements available to its providers.

ii. Must establish appropriate clinical basis for prior authorization criteria.

iii. Must respond to prior authorization requests in accordance with 42 CFR 438.210(d), not later than 72 hours for urgent requests and 14 days for routine dental service requests.

e. Contractor must provide all treatment and diagnostic services as determined necessary by the referring dental provider to correct or ameliorate any conditions found by the referring dental provider.

f. Contractor must provide outreach to Enrollees due or overdue for well-child (preventive)/EPSDT visits, including phone, mail, home-visiting or other means of communication acceptable to the Enrollee; the Contractor may meet this requirement by contracting or collaborating with community-based organizations and providers.

g. The State will inform HKD beneficiaries of their EPSDT benefits.

6. Oral Health Promotion, Outreach and Education

1. Contractor must provide outreach and education to Enrollees that promotes good oral health practices to prevent dental disease in accordance with requirements outlined in section XI. Population Health Management of this Contract.

2. Contractor must not charge an Enrollee a fee for participating in health promotion and education programs for covered services described in this Contract.

3. Contractor must include official HKD branding on all outreach and educational materials.

7. Emergency Services

   a. Contractor must develop, and make available to Enrollees, a dental emergency protocol including directing Enrollees with life threatening emergencies to appropriate emergency services.

   b. Contractor must provide Enrollees a list of after-hours emergency dental providers.

   c. Contractor must make available a toll-free dental emergency contact line 24 hours per day seven days per week.

      The Contractor's dental emergency contact line must respond to each Enrollee emergency request within one hour of request. Unacceptable contact line responses include, but is not limited to:

      i. The contact line is only answered during office hours;

      ii. The contact line is answered after-hours by a recording that tells Enrollees to leave a message;

      iii. The contact line is answered after-hours by a recording that directs Enrollees to go to an Emergency Room for any services needed; and

      iv. Returning after-hours calls outside of four working hours.

   d. Contractor must ensure emergency dental services are available 24 hours per day and seven days per week.

   e. Contractor is prohibited from the following:

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

      ii. 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.

      iii. Denying payment for treatment obtained when an Enrollee had an emergency 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.

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

   f. Contractor must cover and pay for emergency services regardless of whether the emergency provider has a contract with the Contractor.

g. Contractor must be responsible for payment of all out-of-plan or out-of-area dental emergency services and oral examinations provided by a dental emergency provider. Non-contracted providers must not be paid more than the amount that would have been paid if the service had been provided under FFS Medicaid.

h. Contractor must cover emergency dental services regardless of whether the emergency provider notified the Contractor of the Enrollee's Dental Emergency Services.

i. Contractor may not hold an Enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.

j. Contractor is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the Enrollee, determines that the Enrollee is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the enrollee, of when the enrollee is sufficiently stabilized for transfer or discharge is binding on the Contractor for coverage and payment of emergency and post-stabilization services. Contractor must provide dental services needed to evaluate and treat an emergency dental condition found to exist using a prudent layperson standard. Contractor acknowledges that emergency dental providers offering dental emergency services are required to perform a dental examination on emergency clients leading to a clinical determination by the examining dentist that an emergency dental condition does or does not exist. Contractor further acknowledges that if an emergency dental condition is found to exist, the examining dental Provider must provide whatever treatment is necessary to treat the condition of the Enrollee.

k. Contractors are required to cover post-stabilization care services.

    i. Obtained within or outside the Contractor's plan network that are:

        - Pre-approved by a Contractor provider or representative

        - Not pre-approved by a Contractor provider or 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

    ii. Administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within the Contractor's network when the Contractor:

        - Did not respond to a request for pre-approval within 1 hour.

        - Could not be contacted.

        - Representative and the treating physician could not reach agreement concerning the Enrollee's care and Enrollee's physician was not available for consultation.

l. Contractor is required to limit charges to Enrollees for post-stabilization care services to an amount no greater than services through the DHP.

m. Contractor's financial responsibility for post-stabilization care services that were not preapproved ends when:'

i. Enrollee's physician with privileges at the treating hospital assumes responsibility for Enrollee's care.
ii. Enrollee's physician assumes responsibility for the Enrollee's care through transfer.
iii. Contractor representative and the treating physician reach an agreement concerning the Enrollee's care.
iv. The Enrollee is discharged.

8. Transportation

a. Contractor must promote the availability of free, non-emergent medical transportation (NEMT) service benefit for Enrollee healthcare appointments through the Medicaid Health Plan (MHP) or for FFS Enrollees, through local county DHHS office and State transportation contractor in counties in which it operates, including Wayne, Oakland, and Macomb counties.

b. Contractor must provide Enrollees information on how to access the NEMT services for appointments for covered services under this Contract including, but not limited to, telephone numbers, websites, and addresses for such services.

c. Contractor must include NEMT contact information in Enrollee handbooks, promotional and informational materials.

IV. No Cost Sharing

The Contractor and its network providers and Subcontractors must not require any cost sharing responsibilities for HKD Enrollees for Covered Services. The Contractor's network providers are permitted to charge Enrollees for services delivered beyond covered services if the Enrollee is informed of the additional charges and agrees to pay for services beyond covered services prior to services being rendered. The Contractor and its network providers and Subcontractors are prohibited from charging Enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider.

V. Enrollment and Disenrollment

A. Enrollment Services Contractor

MDHHS contracts with an Enrollment Services Contractor to act as its Agent to contact and educate Medicaid beneficiaries regarding dental plan choice and assist beneficiaries to enroll, disenroll, and change enrollment with their dental plan. Contractor must work with the Enrollment Services Contractor as directed by MDHHS.

B. Enrollment Discrimination Prohibited

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

a. Health status or the need for health and/or Dental Services

b. Race, color, national origin, age, disability, sex, 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 all MDHHS assigned Enrollees without restriction.

C. Initial Enrollment and Automatic Reenrollment

1. Contractor must accept as enrolled all beneficiaries listed on all HIPAA-compliant enrollment files/reports.

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

D. Auto-assignment of Beneficiaries

1. MDHHS will initially automatically assign beneficiaries to the Contractor. If there are multiple dental plans assigned to a service area, MDHHS will alternatively assign beneficiaries to a Contractor. Members of a family unit will be assigned together whenever possible.

2. MDHHS has the sole authority for determining the methodology and criteria used for auto-assignment of beneficiaries including, but not limited to historical Enrollee dental utilization, Contractor network capacity and quality algorithms.

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

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

1. In service areas where there are multiple Contractors, MDHHS will provide Enrollees the opportunity to choose a different Contractor annually based upon each Enrollee's enrollment effective date.

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

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

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

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

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

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

F. Enrollment Effective Date

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

2. Contractor must provide covered services and coordination for services to Enrollees until their

date of disenrollment. Changes in enrollment will be approved and implemented by MDHHS on a calendar month basis unless the Contractor is notified of a mid-month disenrollment on the daily enrollment file.

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

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

G. Enrollment Errors by MDHHS

1. If a non-eligible individual who resides outside the Contractor's service area is enrolled with the Contractor and MDHHS is notified within 15 days of enrollment effective date, MDHHS will retroactively disenroll the individual and recoup the capitation payment from the Contractor. Contractor may recoup payments from its Providers as allowed by Medicaid Policy and Contractor's provider contracts. (Note: If MDHHS does not recoup the Capitation Payment, Contractor should not recoup payments to providers.)

2. If a non-eligible individual is enrolled with a Contractor, and MDHHS is notified after 15 days of enrollment effective date, MDHHS will disenroll the Enrollee prospectively the first day of the next available month.

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.

H. Disenrollment from the Contractor

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

2. Enrollees will be disenrolled from the Contractor if the individual:

    a. Loses Medicaid or CHIP eligibility; or

    b. Reaches the age of 21 years.

    c. Moves out of Contractor's service area.

    d. Administrative reasons including, but not limited to death and incarceration.

3. 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 or the Contractor refers the request to MDHHS.

4. If a disenrollment decision is not made within the specified timeframe, the disenrollment is considered approved for the effective date that would have been established had the decision been made in the specified timeframe.

I. Disenrollment Discrimination Prohibited

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

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

    a. Change in physical or mental health status

    b. Utilization of medical and/or dental services

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

J. Special Disenrollments

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

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

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

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

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

K. Enrollees Who Move Out of the Contractor's Service Area (Not Applicable for Contractors with statewide Coverage)

1. Contractor must provide all covered services to an Enrollee who moved out of the Contractor's service area after the effective date of enrollment, until the Enrollee is disenrolled from the Contractor. Contractor may require Enrollees to use network providers and provide transportation and/or authorize out-of-network providers to provide medically necessary services. Contractor may use its utilization management protocols for specialty referrals for Enrollees in this situation.

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

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

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

date.

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

L. Administrative Disenrollments

1. Contractor may initiate disenrollment requests if an Enrollee's circumstances change such that the Enrollee no longer meets the criteria for enrollment with the Contractor as defined by MDHHS, including, but not limited to: Enrollee death, incarceration or move outside of the Contractor's service area.

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

M. Disenrollment Requests Initiated by the Enrollee

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

2. The Enrollee may request a "disenrollment for cause" from current Contractor at any time during the enrollment period for the following reasons.
   a. Enrollee's current Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks and the Enrollee needs related services to be performed at the same time; not all related services are available within the network; and the Enrollee's dental provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.

   b. Lack of access to dental providers or necessary dental specialty services covered under the Contract. An Enrollee must demonstrate that appropriate care is not available within the Contractor's provider network or through non-network providers approved by the Contractor.

   c. If Contractor is unable to provide timely access, in accordance with the network adequacy standards of this Contract, to covered services due to too few in-network Indian healthcare providers (IHCP) or out-of-network access to IHCPs.

   d. If American Indian/Alaska Native Enrollee does not want covered dental services provided through the managed care delivery system.

   e. Enrollee's demonstrated concern with Contractor's quality of care.

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

N. Dental 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 care or services provided. Types of complaints sent from MDHHS include, but are not limited to, any access to care issue, including routine dental care.

a. Within 24-48 hours of receipt of 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. These issues sent from MDHHS may include billing statements, collections notices, and/or written descriptions of the issue.

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

VI. Network Adequacy

A. Network Requirements

1. Contractor must maintain and monitor a network of Medicaid enrolled, qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service area, including counties contiguous to Contractor's service area, for the provision of all covered services.

2. Contractor's provider network must be supported by written agreements and sufficient to provide adequate access to all Covered Services for the maximum number of Enrollees specified under this Contract, including those with limited English proficiency, deaf or hard of hearing, or physical or mental disabilities, CSHCS Enrollees and children with special needs and must submit documentation to MDHHS to that effect. Adequate access to covered services includes compliance with federal regulations at 42 CFR 438 and this Contract.
3. Contractor must 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 dental services are available from network providers within the specified access and travel distance and time requirements identified in Appendices C and D from the Enrollee's home. Provider Network Exceptions, if any, to these access and time and distance standards will be at the discretion of MDHHS. The Provider Network Exception Request is outlined in 1.1 VI. C. 4.

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

6. Contractor must notify Enrollee of MDHHS' published network adequacy standards and provide a printed copy of the network adequacy standards to Enrollees upon request. Delivery method of the printed copy will be determined by the Enrollee's request.

7. Contractor must attest to and demonstrate compliance with contractual network adequacy and timeliness to care requirements through a Network Access Plan on at least an annual basis. As part of Contract compliance review, Contractor must develop, submit, and comply with a Network Access Plan as indicated in **Appendix E**, which describes its network development and network management activities and results. The Network Access Plan

must include any findings of provider Subcontractor non-compliance and any corrective action plan and/or measures taken by the Contractor to bring the provider into compliance. The Network Access Plan must demonstrate that the Contractor:

i. Offers an appropriate range of dental preventive and specialty services that is adequate for the anticipated number of Enrollees for the service area.

ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area.

iii. Monitors and acts on changes or gaps in provider network including exceptions, if any, granted by MDHHS to travel standards, including how the Contractor monitors exceptions, addresses network gaps and improves access and availability to health services across regions and provider specialties.

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

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

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

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

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

13. 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.

14. Contractor must participate in MDHHS initiatives (e.g., HHS CLAS), to promote the delivery of services in a culturally competent manner to all Enrollees including those with limited proficiency in English, deaf and hard of hearing (DHOH), diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

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

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

B. Access to Care and Standards for Timeliness of Appointments

1. The Contractor must:

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

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

c. Establish mechanisms to ensure network providers compliance with network access standards in this Contract, including monitoring network providers regularly to determine compliance and taking corrective action if there is a failure to comply by a network provider.

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

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

   ii. Contractor must provide Enrollees the hours and locations of service for Contractor's network providers' office hours.

   iii. Contractor must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees, or hours of operation comparable to Medicaid FFS, if the provider serves only Medicaid Enrollees.

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

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

g. Monitor network providers regularly to determine compliance, and report to MDHHS on:

   i. The amount of time between scheduling an appointment and the date of the office visit including routine appointments, urgent appointments, and emergent appointments.

   ii. The length of time Enrollees spend waiting in the provider office.

h. Provide for a second opinion from a qualified dental professional within the network or arrange for the Enrollee to obtain one out-of-network at no cost to the Enrollee if not available in-network.

C. 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 sanctions to the Contractor if a network change that negatively affects Enrollees' access to care is not reported timely (**Appendix E**), or the Contractor is not willing or able to correct the issue.

3. Contractor must submit documentation attesting to network adequacy, including modifications to its network access plan, if:

   a. There are changes in services, benefits, service area, or payments.

b. A new population is enrolled.

4. If Contractor discovers changes may affect Contractor's ability to meet time, distance or General Dentist-to-Enrollee ratio standards identified in Appendix D, Contractor must submit a Network Exception Request Form to MDHHS in writing within ten business days. The Provider Network Exception request must include:

    a. County

    b. Provider type

    c. Current provider counts

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

    e. An updated Network Access Plan, as described in Appendix E. must also be submitted with the Network Exception Request Form. The updated Network Access Plan must include:

        i. A plan describing how it will reasonably deliver Covered Services to Enrollees who may be affected by the exception and how Contractor will work to increase access to the 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.

    f. Provider Network Exceptions, if any, will be at the discretion of MDHHS and only considered based on the number of Providers practicing in the identified specialty participating in the DHP service area and other criteria specified in Appendix D and E.

    g. If a Provider Network Exception to a time, distance or General Dentist-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 network exception needs to extend 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.

5. Contractor must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the 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.

D. Out-Of-Network Services

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

covered medically necessary services for the identified Enrollee(s).

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

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

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

5. Contractor must comply with all related Medicaid policies regarding authorization and reimbursement for out-of-network providers.

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

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

E. Access and Timeliness Exceptions

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

1. For general dentistry and pediatric specialist providers:

    a. When the availability of providers in the service area are limited in number and type, especially in areas designated as health professional shortage areas.

    b. The geographic characteristic of the service area is rural in nature.

    c. Service delivery pattern of the service area.

2. When an exception is granted by MDHHS to a Contractor, the exception is granted for a period of up to one year.

    a. The Contractor must develop a plan describing how it will reasonably deliver covered dental services to its Enrollees who will be affected by the exception, included as part of its Network Access Plan.

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

F. Provider Directory

1. Provider Directory

    a. Contractor must maintain a complete Provider directory. 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.

b. Contractor must provide the provider directory in a manner agreeable to the Enrollee either by mail or by utilizing the Contractor's web site. Provider directories must be made available on the Contractor's Web site in a machine-readable file and format.

   i. The provider electronic directory must be made easily accessible to Enrollees. This means the provider directory must have a clearly identifiable link or tab and may not require an Enrollee account or policy number to access the directory.

   ii. Provider directory must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency.

   iii. Contractor must include, in both electronic and print directories, a customer service email address, telephone number and/or electronic link that individuals may use to notify the Contractor of inaccurate provider directory information.

c. Contractor's provider directory must contain, at a minimum, the information listed in **Appendix F** for network providers.

   i. If applicable, the provider directory must include note of prior authorization or referral requirement for certain providers.

   ii. Contractor must periodically audit at least a sample size of its provider directory for accuracy and retain documentation of such audit to be made available to MDHHS upon request. Directory must be audited at least annually.

   iii. General Dentists should only appear in the Provider Directory at locations where they physically present and can provide services a minimum of 20 hours per week.

G. Transition of Care

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

1. The Contractor's transition of care policy must ensure continued access to services during a transition from FFS to a managed care entity, or transition from one managed care entity to another when an Enrollee, in the absence of continued services, would suffer serious detriment to their oral health or be at risk of hospitalization or institutionalization.

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

H. Care Coordination

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

1. Contractor must implement procedures to deliver care to and coordinate services for all Contractor Enrollees. These procedures must meet state requirements and Contractor must coordinate services the Contractor furnishes to the Enrollee:

    a. Between settings of care

    b. With the services the Enrollee receives from any other Managed Care Organization, Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan

    c. With the services the enrollee receives in FFS Medicaid

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

2. Contractor must make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment of all new Enrollees. Contractor must make subsequent attempts to conduct an initial screening of each Enrollee's needs if the initial attempt to contact the Enrollee is unsuccessful.

3. Contractor must share with the state or HKD contractor serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

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

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

VII. Coordination of Services

A. Federally Qualified Health Centers and Rural Health Clinics

All references to FQHCs and RHCs in this section (VII.A) refer only to FQHCs and RHCs offering dental services.

1. Contractor must provide Enrollees with access to dental services provided through FQHCs and RHCs with no authorization required. Contractor must inform Enrollees of this right in their member handbooks.

2. Contractor must include in its provider network at least one FQHC, and one RHC, in each service area region applicable to the Contractor.

3. If a Contractor has an FQHC or RHC in its provider network in the county and allows Enrollees to receive medically necessary services, from the FQHC or RHC, the Contractor has fulfilled its responsibility to provide FQHC and RHC services in network.

4. Contractor must allow Enrollees to access out-of-network FQHCs or RHCs without prior authorization requirement for an out-of-network facility.

5. The Social Security Act requires Contractors pay the FQHCs and RHCs at least as much as the Contractor pays to a non-FQHC or non-RHC provider for the same service. Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs and RHCs.

6. FQHCs and RHCs are entitled, pursuant to the Social Security Act, to prospective payment reimbursement through annual reconciliation with MDHHS. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903(m) organizations (health plans) and the reasonable cost of FQHC or RHC Subcontracts, as applicable with the 1903(m) organization.

B. Indian Healthcare Providers (IHCP)

1. Contractor must:

a. Demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the Contract from such providers for American Indian/Alaska Native Enrollees who are eligible to receive services.

b. Pay IHCPs, 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 IHCP, or

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

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

c. Meet the requirements of FFS timely payment for IHCPs in its network, including the paying of 90% of all clean claims from practitioners within 30 days of the date of receipt; and paying 99% of all clean claims from practitioners within 90 days of the date of receipt.

d. 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.

e. Permit an out-of-network IHCP to refer a American Indian/Alaska Native Enrollee to a network provider.

2. If timely access, within MDHHS' appointment and time and distance standards, to covered services cannot be ensured due to few or no IHCPs, Contractor will be considered to have met the requirement in paragraph (1)(a) of this section if American Indian/Alaska Native Enrollees are permitted by Contractor to access out-of-State IHCPs.

3. If an IHCP Provider is contracted with the Contractor, American Indian/Alaska Natives who are enrolled with the Contractor must be allowed to choose the IHCP Provider as their dental Provider as long as the IHCP dental provider has capacity to provide the services. If the IHCP is not a network provider, American Indian/Alaska Natives must still be allowed to use the provider without authorization.

4. When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service (HIS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

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

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

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

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

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

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

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

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

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

VIII. Dental Provider Selection

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

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

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

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

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

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

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

IX. Enrollee Services

A. Enrollee Rights

1. Contractor must develop and maintain a written policy regarding Enrollee rights and communicate these rights to Enrollees in the member handbook. The Enrollee rights must include, at a minimum, the Enrollee's right to:

    a. Receive information on beneficiary and plan information.

    b. Be treated with respect and with due consideration for his/her dignity and privacy.

    c. Receive Culturally and Linguistically Appropriate Services (CLAS)

    d. Confidentiality

    e. Participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about treatment options.

    f. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

    g. Request and receive a copy of his or her dental records, and request those be amended or corrected.

    h. Be furnished dental services consistent with this Contract and State and federal regulations.

    i. Be free to exercise his or her rights without adversely affecting the way the Contractor, providers, or the State treats the Enrollee.

    j. Be free from other discrimination prohibited by State and federal regulations.

    k. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.

B. Informational Materials for Enrollees

1. Contractor must provide all information required in 42 CFR 438.10 to Enrollees and Potential Enrollees in a manner and format that may be easily understood and is readily accessible by such Enrollees and Potential Enrollees as required in 42 CFR 438.10.

    a. Contractor must make its written materials that are critical to obtaining services, including at a minimum, provider directories, Enrollee handbooks, appeal and grievance notices and denial and termination notices available in the prevalent non- English languages in its Service Area.

    b. For consistency in the information provided to Enrollees and in accordance with 42 CFR 438.10, MDHHS will develop and require Contractor to use specific definitions for managed care terminology and model Enrollee handbooks and Enrollee notices.

    c. All written materials for potential enrollees and current enrollees must be written in a font size no smaller than 12 point.

2. Contractor must use only MDHHS-approved materials and information relating to benefits,

coverage, enrollment, grievances, appeals, or other administrative and service functions, such as member handbooks, newsletters, and other member enrollment materials.

a. Contractor may reuse a letter template previously approved by MDHHS without obtaining additional approval.

b. 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 Dental Health Plans.

c. Informational materials must be written at a 6.9 grade reading level or lower.

3. Contractor must make written materials for potential enrollees and enrollees available in alternative formats in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

4. Contractor must make written materials for potential enrollees and enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

5. Contractor must address the need for culturally appropriate interventions for all Enrollee services.

6. Contractor must make reasonable accommodations for Enrollees with hearing and/or vision impairments (e.g., signing video for deaf and hard of hearing) at no cost to the Enrollee.

7. Contractor must make oral interpretation services available to all Enrollees free of charge; applicable to all non-English languages, not just those languages that meet the definition of Prevalent Language under this Contract.

8. Contractor must establish and maintain a toll-free 24 hours per day, seven days per week telephone number to assist Enrollees.

9. Contractor must issue to all Enrollees an eligibility card that includes:

a. The toll-free 24 hours per day, seven days per week phone number stated above.

b. The Enrollee's Medicaid ID number

C. Member Materials

1. Member Identification Card

a. Contractor must mail member ID cards to Enrollees via first class mail within 10 business days of being notified of the Enrollee's enrollment.

b. All other printed information, not including the member ID card, but including member handbook and information regarding accessing services may be mailed separately from the ID card.

i. Member materials stated above must be delivered to Enrollee within 10 business days of being notified of the member's enrollment.

ii. Contractor may distribute new member packets to each household instead of to each individual member in the household, provided that the mailing includes individual health plan membership cards for each member enrolled in the household when ID cards and other member information are mailed together.

c. Notification must be provided to affected Enrollees when programs or service sites change at least 10 business days prior to changes taking effect.

2. Member Handbook

Contractor must use the state developed Model Enrollee Handbook. Contractor shall make any necessary revisions and distribute to members within timeframe specified by MDHHS.

a. Contractor's member handbook must be written at no higher than a 6.9 grade reading level and be available in alternative formats for children with special needs.

b. Member handbooks must be available in a prevalent language when more than 5% of the Contractor's Enrollees speak a prevalent language, as defined by MDHHS policy.

c. Contractor must provide a mechanism for Enrollees who are blind or deaf and hard of hearing or who speak a prevalent language as described above to obtain member materials and a mechanism for Enrollees to obtain assistance with interpretation.

d. Contractor must make modifications in the handbook language to comply with the specifications of this Contract.

e. Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least once a year and updated when necessary.

f. Contractor must provide the member handbook in a manner agreeable to the Enrollee either by mail or electronically. Member Handbooks will be considered provided to Enrollee if the Contractor:

i. Mails a printed copy of the information to the Enrollee's mailing address.

ii. Provides the information by email after obtaining the Enrollee's written agreement to receive the information by email.

iii. Posts the information on the Contractor's website and advises the Enrollee in paper or electronic form that the information is available on the internet and includes the exact address to access the information. The Contractor must also provide that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

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) and any other information required by MDHHS:

i. Table of contents

ii. Availability and process for accessing covered services that are not the responsibility of the Contractor but are available to its Enrollees.

iii. Description of all available Contract services

iv. Description of no cost sharing to Enrollee

v. Enrollees' rights and responsibilities which must include all Enrollee rights specified in 42 CFR 438.100 (a)(1), 42 CFR 438.100(c), and 42 CFR 438 102(a). The Enrollee rights information must include a statement that conveys that Contractor staff and affiliated providers will comply with all requirements concerning Enrollee rights.

vi. Enrollees' right to receive FQHC, RHC, IHCP (as applicable) and mobile dental facility, and SEAL! Services

vii. Enrollees' right to request information regarding provider incentive arrangements including those that cover referral services that place the dental Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.

viii. Enrollees' right to request information on the structure and operation of the Contractor.

ix. Explanation of any service limitations or exclusions from coverage

x. Explanation of counseling or referral services that the Contractor elects not to provide, reimburse for, or provide coverage of, because of an objection on moral or religious grounds. The explanation must include information on how the Enrollee may access these services.

xi. Grievance, appeal and fair hearing procedures and timeframes including (1) The right to file grievances and appeals and expedited appeals (2) The requirements and timeframes for filing (3) The availability of assistance in the filing process (4) The right to request a State Fair Hearing after the Contractor has made a determination on an Enrollee's appeal which is adverse to the Enrollee (5) The 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 and that the Enrollee may be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee.

xii. How Enrollees can contribute towards their own oral health by taking responsibility, including appropriate and inappropriate behavior

xiii. How to access network dental providers

xiv. How to contact the Contractor's Member Services and a description of its function

xv. How to access out-of-county and out-of-state services

xvi. How to make, change, and cancel appointments with a dental provider

xvii. How to obtain oral interpretation services for all languages, not just prevalent languages as defined by the Contract.

xviii. How to obtain written information in prevalent languages, as defined by the Contract.

xix. How to obtain written materials in alternative formats for Enrollees with special needs

xx. Contractor's toll-free numbers, including the toll-free number Enrollees use to file a grievance or appeal.

xxi. Procedures for obtaining benefits, including any requirements for service authorizations and/or specialty care and for other benefits not furnished by the Enrollee's general dentist.

xxii. Preventive oral health services for Enrollees (EPSDT)

xxiii. 24/7 toll-free dental emergency contact line and dental emergency protocol, to the extent to which, and how, after hours and emergency dental services are provided, including: (1) what constitutes an emergency dental condition and emergency dental services (2) the fact that prior authorization is not required for emergency dental services and (3) The fact that the Enrollee has a right to use any emergency dental provider.

xxiv. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.

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

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

xxvii. Information on how to report suspected fraud and abuse.

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

xxix. Information from Transition of Care Policy on how to access continued services upon transition to the Contractor.

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

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

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

3. 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.

b. Contractors 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.

4. Medicaid Certificate of Coverage

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

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

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

5. Grievance and Appeal Policies and Procedures

a. Contractor must establish and maintain an internal process for the resolution of grievances and appeals from Enrollees.

b. Contractor must have written policies and procedures governing the resolution of grievances and appeals.

c. An Enrollee, or a third party acting on behalf of an Enrollee, may file a grievance or appeal, orally or in writing, on any aspect of covered services as specified in the definitions of grievance and appeal.

d. MDHHS must approve Contractor's grievance and appeal policies prior to implementation. These written policies and procedures must meet the following requirements:

i. Except as specifically exempted in this section, the Contractor must administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F)

ii. Contractor must cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act."

iii. Contractor must have only one level of appeal for Enrollees. An Enrollee may file

a grievance and request an appeal with the Contractor.

iv. Contractor must make a determination on non-expedited appeals not later than 30 calendar days after an appeal is received from the Enrollee. The 30-calendar-day period may be tolled; however, for any period of time the Enrollee is permitted to take under the Medicaid appeals procedure and for a period of time that must not exceed 14 calendar days if (1) the Enrollee requests the extension or (2) the Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest. The Contractor may not toll (suspend) the time frame for appeal decisions other than as described in this section.

v. Contractor must make a determination on grievances within 90 days of the submission of a grievance.

vi. If Contractor extends the timeframes not at the request of the Enrollee, it must:

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

2. Within two calendar days provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file 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 a grievance or appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the Enrollee, the time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the beneficiary that an authorized representative form or document is required. For purposes of this section "third party" includes, but is not limited to, health care providers.

6. Grievance and Appeal Procedure Requirements

Contractor's internal grievance and appeal procedure must include the following components:

a. Contractor must give Enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements in 42 CFR §438.02, §438.10 and §438.404. The notice must explain the following: (1) The adverse benefit determination the Contractor has made or intends to make. (2) The reasons for the adverse benefit determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (3) The Enrollee's right to request an appeal of the adverse benefit determination, including information on exhausting the Contractor's one level of appeal and the right to request a State Fair Hearing. (4) The procedures for exercising their appeal rights, the circumstances under which an appeal process can be expedited and how to request it. (5) The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued.

b. Contractor must mail the adverse benefit determination notice within the timeframes specified in 438.404(c).

c. Contractor must allow Enrollees 60 days from the date of the adverse benefit notice in which to file an appeal.

d. Contractor must provide Enrollees reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

e. Contractor must acknowledge receipt of each grievance and appeal.

f. Contractor must ensure that the individuals who make decisions on grievances and appeals are individuals who:

   i. Are not involved in any previous level of review or decision-making, nor a subordinate of any such individual and;

   ii. Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the grievance or appeal involves a clinical issue. In reviewing appeals for CSHCS Enrollees, the Contractor should utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate, or limit pediatric subspecialist provider services.

   iii. Take into account all comments, documents, records and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

g. Contractor must provide that oral inquires seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal).

h. Contractor must provide the Enrollee a reasonable opportunity, in person and in writing to present evidence, and testimony and make legal and factual arguments. Contractor must inform the Enrollee of the limited time available for this sufficiency in advance of the resolution timeframe for appeals in the case of expedited appeal resolution.

i. Contractor must provide the Enrollee and his or her representative the Enrollee's case file, including dental records, and other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals, specified in §438.408(b) and (c).

j. Contractor must consider the Enrollee, his or her representative, or estate representative of a deceased Enrollee, as parties to the appeal.

k. Contractor must notify the Enrollee in writing of the Contractor's decision on the grievance or appeal.

7. Notice to Enrollees of Grievance Procedure

a. Contractor must inform Enrollees about the Contractor's internal grievance procedures at the time of Initial Enrollment and any other time an Enrollee expresses dissatisfaction by filing a grievance with the Contractor.

b. The internal grievance procedures information must be included in the member

handbook and must explain:

i. How to file a grievance with the Contractor

ii. The internal grievance resolution process

8. Notice to Enrollees of Appeal Procedure

   a. Contractor must inform Enrollees of the Contractor's appeal procedure at the time of Initial Enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to appeal under the definition of appeal in this Contract.

   b. The appeal procedure information must be included in the member handbook and must explain:

      i. How to file an appeal with the Contractor

      ii. The internal appeal process.

      iii. The member's right to a fair hearing with the State after the Contractor's appeal process has been exhausted.

9. Contractor Decisions Subject to Appeal

   a. When the Contractor makes a decision subject to appeal, as defined in this Contract, the Contractor must provide a written adverse benefit determination notice to the Enrollee and the requesting Provider, if applicable. The Contractor must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR §§ 431.211,431.213, and 431.214. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard authorization decisions that deny or limit services, within the timeframe specified in§ 438.210(d)(1). (4) If the Contractor meets the criteria set forth for extending the timeframe for standard authorization decisions consistent with§ 438.210(d)(1)(ii), it must—(i) Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. (5) For standard service authorization decisions not reached within the timeframes specified in § 438.210(d) on the date that the timeframes expire. (6) For expedited authorization decisions, within the timeframes specified in § 438.210(d)(2). Contractor must continue the Enrollee's benefits if all of the following conditions apply:

      i. The Enrollee files the request for an appeal timely in accordance with 438.402(c)(1)(ii) and (c)(2)(ii) which permits Enrollee 60 calendar days from the date on the adverse benefit determination notice to file an appeal.

      ii. The appeal involves the termination, suspension, or reduction of a previously authorized services.

      iii. The services were ordered by an authorized provider.

      iv. The period covered by the original authorization has not expired; and the Enrollee timely files for continuation of benefits, meaning on or before the later of the following:

(iv)i Within 10 days of the Contractor's mailing the adverse benefit determination notice

(iv)ii The intended effective date of the Contractor's proposed adverse benefit determination notice.

b. If the Contractor continues or reinstates the Enrollee's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

i. The Enrollee withdraws the appeal or request for State Fair Hearing.

ii. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the Contractor mails an adverse resolution to the Enrollee's appeal.

iii. A State Fair Hearing decision adverse to the Enrollee is made.

iv. The authorization expires or authorization service limits are met.

c. If the Contractor or State Fair Hearing Officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

d. If the Contractor or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the Contractor must pay for those services.

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.

10. Notice of Resolution for Appeals

a. Contractor must provide written notice of the resolution of the appeals process:

i. In a format and language that, at a minimum, meets applicable notification standards.

ii. And include the results of the appeal resolution.
iii. And include the date of the appeal resolution.

b. For appeal decisions not wholly in the Enrollee's favor, the Contractor will issue an Adverse Benefit Determination Notice.

11. Adverse Benefit Determination Notice

a. Adverse benefit determination notices involving service authorization request decisions that deny or limit services must be made within the time frames described in

this Contract. Adverse benefit determination notices pursuant to claim denials must be sent on the date of claim denial. The Contractor may shorten the period of advance notice to five days before the date of action if—(a) the Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee; and (b) the facts have been verified, if possible, through secondary sources.

b. For termination, suspension, or reduction of previously authorized Medicaid-covered services Contractor must mail adverse benefit determination notices within the following timeframes:

    i. At least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

    ii. The Contractor may send an Adverse Benefit Determination Notice not later than the date of action if (less than 10 days before as required above):

        (ii) i The Contractor has factual information confirming the death of an Enrollee.

        (ii)ii The Enrollee submits a signed written statement that:

            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.

    iii. The Enrollee has been admitted into an institution where he/she is ineligible under the plan for further services.

    iv. The Enrollee's whereabouts are unknown and the post office returns the Contractor's mail directed to the Enrollee indicating no forwarding address.

    v. The Contractor verified with MDHHS that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

    vi. A change in the level of medical care is prescribed by the Enrollee's Provider.

    vii. The notice involves an adverse benefit determination with regard to preadmission requirements.

    viii. The Contractor may shorten the period of advance notice to five days before the date of action if:

        (viii)i The Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee; and

        (viii)ii The facts have been verified, if possible, through secondary sources.

c. The notice must include the following components:

    i. The adverse benefit determination the Contractor or Subcontractor has taken or intends to take.

    ii. The reasons for the Adverse Benefit Determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information including medical

necessity criteria, and any processes, strategies or evidentiary standards used in setting coverage limits.

iii. The Enrollee's right to request an Appeal, including information on exhausting the Contractor's one level of Appeal and the right to request a State Fair Hearing.

iv. An explanation of the Contractor's Appeal process

v. The Enrollee's right to request a Fair Hearing.

vi. How to request a Fair Hearing.

vii. The circumstances under which expedited resolution is available and how to request it.

viii. The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of continued services.

ix. Must be mailed in a timely manner in accordance with 438.404(c)

d. Written adverse action notices must also meet the following criteria:

i. Be translated for the individuals who speak prevalent non-English languages as defined by the Contract.

ii. Include language clarifying that oral interpretation is available for all languages and how the Enrollee can access oral interpretation services.

iii. Use easily understood language written below the 6.9 reading level.

iv. Use an easily understood format.

v. Be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs.

12. State Medicaid Appeal Process

a. The State will maintain a Fair Hearing process to ensure Enrollees have the opportunity to Appeal decisions directly to the State. Any Enrollee dissatisfied with a State agency determination denying an Enrollee's request to transfer Contractors/disenroll has access to a State Fair Hearing.

b. Contractor must include the Fair Hearing process as part of the written internal process for resolution of Appeals and must describe the Fair Hearing process in the member handbook. The parties to the State Fair Hearing may include the Contractor as well as the Enrollee and her or his representative or the representative of a deceased Enrollee's estate.

c. An Enrollee may request a State Fair Hearing only after receiving notice that the Contractor has upheld its adverse benefit determination.

i. If the Contractor fails to adhere to the required appeals notice and timing requirements in 438.408, the Enrollee is deemed to have exhausted the Contractor's appeals process.

d. The Contractor must allow the Enrollee 120 days from date of the Contractor's Appeal

resolution notice to request a State Fair Hearing

13. Expedited Appeal Process

    Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Enrollee) or when 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, physical or mental health, or ability to attain, maintain, or regain maximum function. 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.

14. Grievance and Appeals Records

    Contractor and its subcontractors as applicable, must maintain record of all grievance and appeals.

    a. The record of each grievance and appeal must contain, at a minimum, all of the following:

        i. A general description of the reason for the appeal or grievance

        ii. The date received.

        iii. The date of each review or, if applicable, review meeting

        iv. Resolution at each 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.

    b. Grievance records must be accurately maintained in a manner accessible to the State and available upon request to CMS.

    c. Grievance and appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

D. Services for Children in Foster Care

1. Contractor must identify providers that are willing and able to serve as a dental home back-up for required dental exams that are deemed urgent for children in Foster Care.

2. Contractor must authorize and reimburse all required Foster Care initial dental exams for children in care, including any that occurred with an out-of-network provider.

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.

4. Contractors must provide care coordination to all Enrollees with a Foster Care indicator.

X. Provider Services

A. Provider Services

1. Contractor must provide contract and education services for the provider network, including education regarding fraud and abuse.

2. Contractor must properly maintain dental records.

3. Contractor must process provider grievances and appeals in accordance with Contract and regulatory requirements.

4. Contractor must develop and maintain an appeal system to resolve claim and authorization disputes.

5. Contractor must maintain a written plan detailing methods of provider recruitment and education regarding Contractor policies and procedures.

6. Contractor must maintain a regular means of communicating and providing information on changes in policies and procedures to its Network Providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, or a regular provider newsletter.

7. Contractor must provide a staff of sufficient size to respond promptly to provider inquiries, questions, and concerns regarding covered services, within timeframes that do not impede the provider's ability to provide services to Enrollees.

8. Contractor must provide a copy of the Contractor's prior authorization policies to the provider when the provider joins the Contractor's provider network. Contractor must notify providers of any changes to prior authorization policies as changes are made.

9. Contractor must make available provider policies, procedures, and appeal processes via Contractor website. Updates to the policies and procedures must be available on the website as well as through other media used by the Contractor.

10. Contractor must promote among its network providers, the overall goals, objectives, and activities of the 2025 Michigan State Oral Health Plan.

B. Provider Contracts

Contractor must comply with the following provisions and include the following information in provider contracts:

1. Prohibit the provider from seeking payment from the Enrollee for any covered services provided to the Enrollee within the terms of the contract and require the provider to look solely to the Contractor for compensation for services rendered.

2. Require the provider to cooperate with Contractor's quality improvement and utilization review activities.

3. Include provisions for the immediate transfer of Enrollees to another Contractor dental provider if the Enrollees' health or safety is in jeopardy.

4. Include provisions stating that providers are not prohibited from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.

5. Include provisions stating that providers, acting within the lawful scope of practice, are not prohibited, or otherwise restricted from, advising, or advocating on behalf of an Enrollee who is his or her patient:

    a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    b. For any information, the Enrollee needs in order to decide among all relevant treatment options.

    c. For the risks, benefits, and consequences of treatment or non-treatment

    d. For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6. Require providers to meet Medicaid accessibility standards as defined in this Contract.

7. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider.

8. Require providers to take Enrollees' rights into account when providing services as outlined in 42 CFR 438.100.

9. Ensure Enrollees are not denied a covered service or availability of a facility or provider identified in this Contract.

10. Require providers to not intentionally segregate Enrollees in any way from other persons receiving dental services.

11. Require health professionals to comply with reporting requirements for communicable disease and other health indicators as mandated by State law.

C. Provider Participation

1. Contractors must not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2. This provision should not be construed as an "any willing provider" law, as it does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Enrollees.

3. This provision does not interfere with measures established by the Contractor designed to maintain quality and control costs consistent with the responsibility of the organization.

4. If Contractor declines to include provider's in-network, the Contractor must give the affected providers written notice of the reason for the decision.

5. Contractor must implement and comply with written policies and procedures for selection and retention of network providers that, at a minimum, meet uniform credentialing and recredentialing policy established by MDHHS in consultation with Contractors that addresses acute, primary, mental, and substance use disorders, as appropriate.

D. Provision of Enrollee Grievance, Appeal and Fair Hearing Procedures to Providers

Contractor must provide the following Enrollee grievance, appeal, and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

1. The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing.

2. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

3. The availability of assistance to the Enrollee in filing.

4. The toll-free numbers to file oral grievances and appeals.

5. The Enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing and that if the Contractor's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

E. Provider Credentialing and Recredentialing

Contractor must comply with all applicable State and/or federal credentialing/recredentialing requirements of providers within the Contractor's network, including, but not limited to the requirements specified in this section.

1. Contractor must have written credentialing and recredentialing policies and procedures that do the following:

    a. Ensure quality of care.

    b. Ensure that all providers rendering services to Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract.

    c. Verify that the provider is not debarred or suspended by any State or federal agency.

    d. Require the provider to disclose criminal convictions related to federal health care programs.

e. Review the provider's employees to ensure that these employees are not debarred or suspended by any State or federal agency.

f. Require the provider's employees to disclose criminal convictions related to federal health care programs.

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.

3. Payment Resolution Process

a. Contractor must develop and maintain an effective provider appeal process to promptly resolve provider billing disputes and other issues.

b. Contractor must cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution processes.

4. Enrollee Liability for Payment

Contractor or Contractor's providers must not hold Enrollees liable for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR 438.116 (i.e., prohibition on balance billing the Enrollee):

a. Debts of the Contractor, in case of insolvency

b. Covered services under this Contract provided to the Enrollee for which MDHHS did not pay the Contractor.

F. Payment Reform-Value Based Payment Models

1. 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 HKD beneficiaries. Value-based payment models include, but are not limited to:

a. Total capitation models

b. Limited capitation models

c. Bundled payments.

d. Supplemental payments to build practice-based infrastructure and Enrollee management capabilities.

e. Payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable.

2. Contractor will give consideration for future efforts to increase oral health care services reimbursed under value-based contracts that include as one of its provider goals an increase in Preventive dental utilization services.

XI. Population Health Management

A. Data Aggregation and Analysis

1. General

a. Contractor must have the ability to stratify population health data as indicated in **Appendix G** (e.g., age, gender, race, ethnicity, etc.).

b. MDHHS will provide the Contractor with population health data on the 834-enrollment file.

2. Data Analysis to Support Population Health Management

a. Contractor must utilize information such as enrollment files (834), claims, encounter data supplemented by utilization management data and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address oral health disparities, improve community collaboration, and enhance care coordination between the Contractor's provider network and Enrollee physicians and/or specialists.

b. Social determinants to be included in data analysis must include:

i. Subpopulations experiencing a disparate level of social needs such as housing and federal poverty level.

ii. Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.

iii. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.

iv. Persons with high prevalence chronic conditions, such as diabetes, obesity, and cardiovascular disease.

v. Enrollees in need of complex care management, including high risk Enrollees with dual mental health and medical health diagnoses who are high utilizers of services.

vi. Other populations with unique needs as identified by MDHHS such as foster children or homeless members.

3. Data Reporting

a. Upon MDHHS request, Contractor must report clinical measures and stratify these reports based on Population Health data supplied by MDHHS.

b. Contractor must provide reports for performance projects using population health data.

B. Oral Health Promotion and Disease Prevention

1. Oral Health Promotion and Outreach

a. Contractor must use the 2025 Michigan State Oral Health Plan as part of its guidance in the development of its health promotion and outreach strategies.

b. Prior to implementation, the Contractor must submit to MDHHS, as part of its Contract compliance review, an annual plan on its health promotion and outreach activities, including outreach, referral, and activities related to Enrollee uptake and participation rates.

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

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

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

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

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

iii. Include outreach activities each year with no less than one per quarter. Activities must include member related activities and events must be conducted statewide including but not limited to metropolitan and rural areas each year. The number of annual outreach activities including rural outreach will be determined by MDHHS.

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

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

f. Contractor must provide Enrollees and families the opportunity to provide feedback to inform health equity initiatives. This can be achieved through an MDHHS approved member survey.

2. Education and Disease Prevention

a. Contractor must provide its Enrollees with educational materials that promote good

oral health practices, including coordination between oral and medical appointments.

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

   i. Contractor bulletins or newsletters sent to Enrollees at least two times per year that provide updates related to covered services, access to providers, and updated policies and procedures.

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

   iii. Information regarding the appropriate use of oral health services and prevention of Fraud, Waste, and Abuse.

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

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

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

      (iv) iii Only Contractors' Enrollees may participate.

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

      (v)i Preventive oral health strategies

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

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

      (v)iv Complete provider directory, and

      (v)v Updated policies and procedures

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

d. Contractor must ensure its Enrollees have access to evidence-based/best practices educational programs, through Contractor programs or referral to local public health/community-based programs, that increase Enrollees' understanding of common risk factors, and evidence-based/best practices wellness programs to engage and track Enrollees' participation in activities that reduce the impact of common risk factors.

e. Such education and wellness programs must be available to Enrollees through multiple sources, which may include, but are not limited to websites, social media vehicles, in dental offices and facilities, public schools and through mailings.

f. Contractor must implement educational, public relation and social media initiatives to increase Enrollee and network provider awareness of public health programs and other community-based resources that are available and designed to reduce the impact of social determinants of oral health and other common risk factors, such as the

community-based public health resources designed to promote Enrollee wellness and available at: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_6226-145381--,00.html

g. Contractor must collaborate with community-based organizations to facilitate the provision of Enrollee oral health education services to ensure the entire spectrum of social determinants of oral health are addressed (e.g., housing, healthy diet, and physical activity).

C. Oral and Medical Health Coordination

1. Coordination of Care

a. Contractor recognizes the importance of coordinating oral and medical health services in order to effectively address and improve Enrollee overall health status.

b. Contractor must work with MDHHS to develop initiatives to better coordinate services covered by the Contractor and medical staff serving Contractor's Enrollees.

c. Contractor must collaborate with primary care providers, community partners, Medicaid health plans, and MDHHS in the treatment of Enrollees collectively served among these parties.

d. Contractor must develop a coordination of care policy as part of the Contractor compliance review, that promotes dental and medical service collaboration among its network providers and submit to MDHHS for approval prior to implementation. As part of its coordination of care policy, the Contractor must require its network providers to participate in coordinated care for Enrollees. Coordinated care includes, but is not limited to, communication and collaboration with Enrollee health care team members such as physicians, case managers and community health workers (CHW) to ensure continuity of care.

e. Contractor must engage in activities that increase awareness about impact of oral health on Enrollee chronic disease outcomes and improve communication and Collaboration among dental Providers, community partners and medical professionals.

f. Contractor must coordinate care with the school-based program SEAL! and mobile dental facilities.

g. Contractor must engage in activities that will educate and build awareness of the benefits of integrated care to its dental Providers.

h. Contractor must build relationships with community partners that will engage in integrated care and promote good oral health practices.

i. Contractor must work collaboratively with community partners to incorporate oral health into the Michigan Community Health Workers curriculum.

D. Children Enrolled in Foster Care

1. Contractor must provide care coordination to all Enrollees with a Foster Care indicator.

2. 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 receive an initial dental examination within the first 90 Days of entering foster care when required.

a. Contractor must adhere to the foster care dental exam protocol provided by the department.

3. 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.

XII. Quality Improvement and Program Development

A. Quality Assessment and Performance Improvement Program (QAPI)

1. Contractor must have an ongoing QAPI program for the services furnished to its Enrollees that meets the requirements of 42 CFR 438.330.

2. Contractor's QAPI must include a) performance improvement projects, b) collection and submission of performance measurement data, c) mechanisms to detect both underutilization and overutilization of services, and d) mechanisms to assess the quality and appropriateness of care furnished to children with special needs.

3. Contractor's Dental Director must be responsible for managing the QAPI program.

4. Contractor must maintain a Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results, and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including, but not limited to the Quality Improvement Director, the Dental Director and other key management staff, as well as health professionals providing care to Enrollees.

5. Contractor's QAPI program must:

   a. Incorporate activities required in the Population Health Management section of this Contract into the Contractor QAPI program.

   b. Identify opportunities to improve the provision of dental services and the outcomes of such care for Enrollees.

   c. Incorporate and address findings of Contract compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies.

   d. Develop or adopt performance improvement goals, objectives, and activities or interventions to improve service delivery or oral health outcomes for Enrollees.

   e. Be made available to MDHHS annually through the Contract compliance review or on request.

6. Contractor must have a written plan for the QAPI program that must be submitted to the MDHHS as part of the annual Contract compliance review. The plan must include, at a minimum, the following:

   a. Contractor's performance goals and objectives

   b. Lines of authority and accountability

   c. Data responsibilities

d. Performance improvement activities

e. Evaluation tools

f. Solicits member and network provider input for activities.

g. Foster data driven decision making.

h. Supports ongoing measurement of clinical and non-clinical effectiveness and member satisfaction.

i. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements.

j. Evaluates performance using objective quality indicators.

7. The written plan must describe how the Contractor will:

a. Analyze the processes and outcomes of care using currently accepted standards from recognized oral health authorities. The Contractor may include examples of focused review of individual cases, as appropriate.

b. Analyze data, including social determinants of oral health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees.

c. Develop system interventions to address the underlying factors of disparate utilization, health-related behaviors, and oral health outcomes, including, but not limited to, how they relate to utilization of dental emergency services.

d. Use measures to analyze the delivery of services and quality of care, over and underutilization of services, oral health disease management strategies, and outcomesof care. Contractor must collect and use data from multiple sources such as dental records, encounter data, claims processing, grievances, utilization review, and member satisfaction instruments in this activity.

e. Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement and integrate the work of the Community Collaboration Project into their overall QAPI program.

f. Compare QAPI program findings with past performance and with established program goals and available external standards.

g. Measure the performance of providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers.

h. At least annually, provide performance feedback to providers, including detailed discussion of current dental standards and expectations of the Contractor.

i. Develop and/or adopt, and periodically review, clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards and makes these clinical practice guidelines available to Enrollees upon request.

j. Ensure that, where applicable, utilization management, Enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines.

k. Evaluate access to care for Enrollees according to the established standards and those developed by MDHHS and Contractor's QIC and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

l. Perform an annual member satisfaction survey according to MDHHS specifications and distribute results to providers, Enrollees, and MDHHS.

m. Implement improvement strategies related to program findings and evaluate progress at least annually.

n. Ensure the equitable distribution of dental services to Contractor's entire population, including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities.

o. Collect and report data as proscribed by MDHHS including, but not limited to: HEDIS®, CAHPS, and other MDHHS-defined measures that will aid in the evaluation of quality of care of all populations.

B. Annual Effectiveness Review

Contractor must conduct an annual effectiveness review of its QAPI program that includes:

1. Analysis of improvements in the access and quality of dental care and services for Enrollees as a result of quality assessment and improvement activities and targeted interventions carried out by the Contractor.

2. Consideration of trends in service delivery and oral health outcomes over time and include monitoring of progress on performance goals and objectives.

3. Information on the effectiveness of the Contractor's QAPI program must be provided annually to network providers, upon request by Enrollees, and annually to MDHHS through the Contract compliance review or upon request.

C. Annual Performance Improvement Projects

1. Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas including any performance improvement projects required by CMS.

2. Each performance improvement project must be designed to achieve significant improvement, sustained over time, in oral health outcomes and Enrollee satisfaction, and must include the following elements:

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, Caries Risk Assessment (CRA), utilization, or outcomes.

4. MDHHS will collaborate with stakeholders and the Contractor to determine priority areas for statewide performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the population and children with special needs as defined by MDHHS.

5. Contractor must assess performance for the priority areas identified through the Collaboration of MDHHS and other stakeholders.

6. Contractor must report the status and results of each project conducted to MDHHS as requested, but not less than once per year.

D. Performance Monitoring

MDHHS has established annual performance monitoring standards.

1. Contractor must incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QAPI program.

2. MDHHS may use the results of performance assessments as part of the formula for bonus awards and/or automatic enrollment assignments. MDHHS will continually monitor the Contractor's performance on the performance monitoring standards and make changes as appropriate. The performance monitoring standards are attached to the Contract (**Appendix I**); the performance bonus template is attached to the Contract (**Appendix J**).

E. External Quality Review

MDHHS will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the Contractor. Contractor shall 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 Enrollee population using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument.

2. Contractor must directly contract with a National Committee for Quality Assurance (NCQA) certified CAHPS® vendor and submit the data according to the specifications established by NCQA.

3. Contractor must provide NCQA summary and member level data to MDHHS annually.

4. Contractor must provide an electronic or hard copy of the final survey analysis report to MDHHS upon request.

G. Utilization Management

1. The utilization management (UM) activities of the Contractor must be integrated with the Contractor's QAPI program.

2. The major components of Contractor's UM program must encompass, at a minimum, the following:

    a. Written policies with review decision criteria and procedures that conform to dental industry standards and processes.

    b. A formal utilization review committee directed by the Contractor's dental director to oversee the utilization review process.

    c. Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

3. An annual review and reporting of utilization review activities and outcomes/interventions from the review must be submitted as part of the annual Contract compliance review. Contractor must establish and use a written prior approval policy and procedure for UM purposes.

    a. The policy must ensure the review criteria for authorization decisions are applied consistently and require the reviewer consult with the requesting provider when appropriate.

4. The policy must also require UM decisions be made by a dental professional who has appropriate clinical expertise regarding the service under review.

5. Contractor must not use UM policies and procedures to avoid providing medically necessary services within the coverages established under the Contract.

6. Contractor's authorization of services policy must establish timeframes for standard and expedited authorization decisions.

    a. These timeframes may not exceed 14 calendar days from date of receipt for standard authorization decisions and 72 hours from date of receipt for expedited authorization decisions.

    b. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's dental health, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's dental condition requires and no later than 72 hours after receipt of the request for service.

7. These timeframes may be extended up to 14 additional calendar days if:

    a. The Enrollee or the Provider, requests an extension; or

    b. The Contractor justifies (to the State agency upon request) the need for additional information and explains how the extension is in the Enrollee's interest. The Enrollee must be notified in writing of the plan's intent to extend the timeframe.

8. Contractor must ensure that compensation to the individuals or subcontractor that conduct utilization management activities is not structured so as to provide incentives for the individual or Subcontractor to deny, limit, or discontinue medically necessary services to any Enrollee. If an authorization decision is not made within the specific timeframes, the Contractor must

issue an adverse action notice.

H. Performance Measure Data Quality

1. DHHS 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.

6. Contractor must participate in MDHHS' Performance Measure Quality Activities. Contractor must:

    a. Attend and participate in all MDHHS scheduled performance measure quality meetings.

    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 corrective action and/or penalties.

XIII. Management Information Systems

A. Management Information System (MIS) Capabilities

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

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

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

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

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

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

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

ii. Utilization/Quality management

iii. Case management

iv. Provider enrollment

v. Coordination of benefits/third party liability activity

vi. Claims payment.

vii. Encounter data

viii. Benefit tracking

ix. Clinical management

x. Reporting

xi. Interface

xii. Fraud, Waste, and Abuse

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

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

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

h. The Contractor must provide MDHHS any updates to the Contractor's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of any change. The Contractor must provide MDHHS with official points of contact within its organization for MIS issues, and timely notify MDHHS when these contacts change.

B. System Functionality

1. The Contractor's MIS must include key business processing functions and/or features, which must apply across all subsystems as follows:

a. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;

b. Track medically necessary covered services received by Enrollees through the system, and accurately and fully maintain those medically necessary covered services as HIPAA-compliant encounter transactions;

c. Transmit or transfer encounter data transactions on electronic media in the HIPAA format to the Contractor designated by MDHHS to receive the encounter Data;

d. Maintain a history of changes and adjustments and audit trails for current and retroactive data;

e. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure, as indicated in Section XVII;

f. Employ industry standard dental billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and encounter transactions produced;

g. Accommodate the coordination of benefits;

h. Ability to produce standard explanation of benefits (EOBs);

i. Pay financial transactions to providers in compliance with federal and State laws, rules, and regulations;

j. Ensure that all financial transactions are auditable according to generally accepted accounting principles;

k. Relate and extract data elements to produce report formats required by MDHHS;

l. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;

m. Maintain and cross-reference all Enrollee-related most current information;

n. Include Medicaid or CHIP Program Provider number;

o. Track utilization of benefits;

p. Report benefit utilization information to MDHHS;

q. Track provider NPI number; and

r. Must use Medicaid beneficiary identification as primary Enrollee identification.

2. The Contractor must assure that systems services are not disrupted or interrupted during the Contract period. The Contractor must ensure the business and systems continuity for the processing of all dental claims and data as required under this Contract.

a. The Contractor must submit to MDHHS, descriptions of interface and data and process flow for each key business process described in the MIS section of this Contract.

b. The Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities including:

i. Security Plan;

ii. Joint Interface Plan;

iii. Risk Management Plan; and

iv. Systems Quality Assurance Plan.

c. Contractor must submit any revisions to the above-mentioned documents for MDHHS review and approval 30 days prior to implementation.

C. Health Insurance Portability and Accountability Act (HIPAA) Compliance

1. Contractor's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

2. Contractor must comply with Accredited Standards Committee (ASC) X12 Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant version.

3. Contractor's enrollment files transferred to providers and/or subcontractors must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 835 format.

4. Contractor must be 5010 and International Statistical Classification of Diseases and Related Health Problems (10th Edition) (ICD-10) compliant.

5. Contractor must provide its members with a privacy notice as required by HIPAA and provide MDHHS with a copy of its standard privacy notices.

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

D. Enrollment Data

MDHHS will provide HIPAA-compliant daily and monthly enrollment files to the Contractor via the 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 Enrollees.

2. Contractor must load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's vendors (e.g., network providers) on or before the first of the month so that Enrollees have access to services.

3. Contractor must reconcile the daily and monthly 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.

E. Encounter Data

1. Contractor must submit complete and accurate Encounter Data to MDHHS in the form and manner described in 42 CFR 438.818 and MDHHS guidance including but not limited to MDHHS:

    a. Companion Guides/Data Clarification Documents

    b. Electronic File Layout Instructions

    c. Encounter Reporting Presentations

    d. In addition, encounter data reporting requirements shall be posted on the following 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. MDHHS will deem encounter data submitted when it is accepted, certified, and processed in MDHHS systems.

4. Within seven days of the original submission attempt, Contractor shall correct and resubmit files that fail to load in their entirety.

5. 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.

6. 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.

7. Encounter records must be submitted monthly as specified in Appendix H via electronic media in a HIPAA compliant format as specified by MDHHS.

8. Timely and complete encounter data submission must be made by the 15th of the month while meeting minimum volume requirements.

9. 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 sanctions, penalties, and/or liquidated damages.

    a. Calculation: Total number of Accepted encounter records / Total number of encounter records submitted ≥ x%

10. 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. (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 sanctions, penalties, and/or liquidated damages.

a. There are two calculations used to check for the matching percentage.

i. Contractor ERN on list with match in MDHHS data warehouse

i. Calculation: Total number of matched ERN encounter records by invoice type / Total number of submitted ERN encounter records submitted by invoice type ≥x%

ii. MDHHS data warehouse ERN with match on Contractor ERN list

i. 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%

11. Contractor must populate all fields required by MDHHS including, but not limited to, financial data for all encounters. Submitted encounter data will be subject to quality data edits prior to acceptance into MDHHS's data warehouse. The Contractor's data must pass all required data quality edits in order to be accepted into MDHHS's data warehouse. Any data that is not accepted into the MDHHS data warehouse will not be used in any analysis, including, butnot limited to, rate calculations and risk score calculations. MDHHS will not allow Contractorsto submit incomplete encounter data for inclusion into the MDHHS data warehouse and subsequent calculations.

12. Contractor will be held responsible for errors or noncompliance 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.

13. 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.

14. 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.

15. 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 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

16. 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 liquidated damages, sanctions, and penalties in accordance with contract standards.

17. 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 non-compliant performance and MDHHS may pursue contract remedies including but not limited to liquidated damages, sanctions, and penalties in accordance with contract standards.

18. For reporting claim encounters submitted on 837D format, Contractor must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by MDHHS. Any exceptions will be considered on a code-by-code basis after MDHHS receives written notice from the Contractor requesting an exception.

F. 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 and

    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 duplicated 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 to MDHHS upon 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 shall 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.

    b. Submit timely completed data template requests and Appendices, in accordance with the Encounter Quality Initiative Schedule

    c. Submit timely completed EQI reconciliation comparison report in accordance with the Encounter Quality Initiative Schedule

    d. 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 sanctions, penalties, and/or liquidated damages.

G. Data Accuracy

1. Contractor must ensure all encounter data is complete and accurate for the purposes of rate calculations and quality and utilization management.

2. Contractor must ensure data received from providers is accurate and complete by:

    a. Verifying the accuracy and timeliness of the data

    b. Screening the data for completeness, logic, and consistency

    c. Collecting service information in standardized formats

    d. Identifying and tracking Fraud, Waste and Abuse

H. Electronic Billing Capacity

1. Contractor must offer its providers the option of submitting and receiving claims information through an EDI that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

2. Contractor must make an Electronic Funds Transfer (EFT) payment process (for direct deposit) available to network providers.

3. Contractor must meet the HIPAA and MDHHS guidelines and requirements for electronic billing capacity and must require its providers to meet the same standard as a condition for payment.

4. Contractor must ensure providers bill the Contractor using the same format and coding instructions required for the Medicaid FFS programs according to Medicaid policy.

5. Contractor must not require providers to complete additional fields on the electronic forms not specified in Medicaid FFS Policy.

6. Contractor may require additional documentation, such as medical records, to justify the level of care provided.

7. Contractor may require prior authorization for services for which the Medicaid FFS program does not require prior authorization except where prohibited by other sections of this Contract or Medicaid policy.

8. Contractor must maintain the completeness and accuracy of their websites regarding this information.

I. Claims Processing Requirements

1. The Contractor must maintain an automated claims processing system that registers the date a claim is received by the Contractor, the detail of each claim transaction (or action) at the time the transaction occurs and has the capability to report each claim transaction by date and type to include interest payments.

2. The Contractor claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to MDHHS.

3. The Contractor's claims system must maintain online and archived files and keep online automated claims payment history for the most current 36 months.

4. The Contractor must retain financial information and records, including all original claim forms, for the time period in accordance with all federal and State laws.

5. All claims data must be easily sorted and produced in formats as requested by MDHHS.

J. Payment to Providers

1. Timely Payments

Contractor must make timely payments to all providers for covered services rendered to Enrollees as required by 42 CFR §447.45 and MCL 400.111i and in compliance with established MDHHS performance standards.

a. Contractor must pay 90% of all clean claims from providers within 30 days of the date of receipt.

b. Contractor must pay 99% of all clean claims from providers within 90 days of the date of receipt.

c. Clean claim will mean all claims as defined in 42 CFR §447.45 and MCL 400.111i.

d. Contractor must 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 allowable 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 submitting an annual IRS form 1099, reporting of provider earnings to each provider who receives a payment for services during the calendar year, and must make all collected data available to MDHHS and, upon request, to CMS.

j. Contractor must develop programs to facilitate outreach, education and prevention services with both network and out-of-network providers.

k. Contractors must provide an annual summary of the outreach, education, and prevention services as part of the annual report due to MDHHS on March 1 of each year.

2. Provider Preventable Conditions

a. Contractor is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria:

i. Are outlined in the Michigan Medicaid State Plan

ii. Has been found by MDHHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

iii. Has a negative consequence for the beneficiary.

iv. Is auditable.

v. 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 to MDHHS on a monthly basis.

3. Post-Payment Review

    a. Contractor must utilize a post-payment review methodology to assure claims have been paid appropriately.

    b. Contractor must complete post-payment reviews for individuals retroactively disenrolled by MDHHS for incarceration within 90 days of the date MDHHS notifies the Contractor of the retroactive disenrollment. This disenrollment is identified with a disenrollment reason code of I on the 5629 834 daily enrollment file.

    c. Contractor must not recoup money from Providers for individuals retroactively disenrolled for incarceration 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 5629 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 5629 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 V.C.2). 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.

        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 V.G.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.

K. Automated Contact Tracking System

Contractor must utilize the MDHHS Automated Contact Tracking System to submit the following requests:

1. Disenrollment requests for out of area Enrollees who appear in the wrong county on the Contractor's enrollment file (as applicable).

2. Other administrative requests specified by MDHHS.

L. Provider File

1. Provider files are used by the Enrollment Broker to convey information to beneficiaries on available contractors and network providers for each Contractor.

2. MDHHS utilizes the provider file to ensure the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation.

3. Contractor must submit provider files that contain a complete and accurate description of the provider network available to Enrollees according to the specifications and format delineated by MDHHS to the MDHHS enrollment services contractor.

4. The Provider file must contain all network providers.

5. The Contractor must specifically identify any providers that are IHCPs.

6. Contractor must submit a provider file that passes all MDHHS quality edits to the MDHHS enrollment services contractor at least once per month, and more frequently, if necessary, to ensure changes in the Contractor's provider network are reflected in the provider file as required in this Contract.

M. Network Adequacy Provider File (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.

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.

XIV. Health Information Exchange/Health Information Technology

Contractor must support MDHHS initiatives to increase the use of HIE/HIT to improve care coordination; reduce Fraud, Waste and Abuse; and improve communication between systems of care.

A. Electronic Health Records (EHR)

MDHHS has established rules and guidelines to advance the adoption and meaningful use of certified EHR technology through the Medicare and Medicaid EHR Incentive Programs authorized by the HITECH.

1. Contractor must promote EHR as part of regular provider communications.

2. Contractor must electronically exchange eligibility and claim information with providers to

promote the use of EHR.

3. Contractor must comply with MDHHS performance programs designed to advance provider adoption and meaningful use of certified EHR.

B. Electronic Exchange of Client Level Information

1. Contractor must promote the benefits of electronic exchange of client information in overall treatment of patient.

2. Contractor must have the ability to coordinate Enrollee care among other providers.

XV. Observance of State and Federal Laws and Regulations

A. General

1. Contractor must comply with all State and federal laws, statutes, regulations, and administrative procedures and implement any necessary changes in policies and procedures as required by MDHHS.

2. Federal regulations governing contracts with risk-based Pre-paid Ambulatory Health Plans (PAHPs) are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract.

3. 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. 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.

5. 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 statutory requirements for fiscal soundness and MDHHS will evaluate the Contractor's financial soundness based upon the thresholds established in **Appendix K** 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 have a Certificate of Authority to operate in the State of Michigan in accordance with applicable Michigan Compiled Laws under the authority of the Insurance Director.

2. Contractor must disclose to MDHHS its accreditation status by a private independent accrediting entity.

    a. If the Contractor has received accreditation by a private independent entity, the Contractor must authorize the private independent accrediting entity to provide MDHHS a copy of its most recent accreditation review including:

        i. Accreditation Status

        ii. Recommended actions or improvements, corrective action plans and summaries of findings; and

        iii. The expiration date of the accreditation.

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 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 services, performs billing or coding functions, or is involved in monitoring of Medicaid services provided by the entity.

5. If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees regarding detection and prevention of fraud, waste and abuse including an explanation of the false claims acts and of the rights of employees to be protected as whistleblowers.

E. Protection of Enrollees against Liability for Payment and Balanced Billing

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

F. 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. Prohibition of Additional Payments to Providers

1. MDHHS will ensure that no payment is made to a network provider other than by the Contractor, PIHP, or PAHP for services covered under the contract between MDHHS and the Contractor, except when these payments are specifically required to be made by MDHHS in Title XIX of the Act, in 42 CFR, or when MDHHS makes direct payments to network providers for graduate medical education costs approved under the state plan.

H. Third Party Resource Requirements

Third Party Liability (TPL) refers to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, PAHPs, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the approved Medicaid state plan. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to be made whole, including recoveries from any related court judgment or settlement if Contractor has been notified of the legal action. Contractor must follow the "Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing" as described in the Michigan State Medicaid Plan, Attachment 4.22-B, Page 1. Contractor may pursue cases below the thresholds at their discretion.

1. Contractors must seek to identify and recover all sources of third-party funds based on industry standards 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 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, TPL Guidelines and Best Practices or available upon request. Contractor use of best practices is strongly encouraged by MDHHS and are available in the TPL Guidelines and Best Practices. Contractor must develop and implement written policies describing its procedures for TPL recovery. MDHHS will review Contractor's policies and procedures for compliance with this Contract and for consistency with TPL recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.

4. Contractor must report third party collections through encounter data submission and in aggregate as required by MDHHS.

5. Throughout the Contract term, Contractor must comply in full with the provision of third-party recovery data to MDHHS in the electronic format prescribed by MDHHS. Recovery data will be collected on a quarterly basis starting with January data. Activities performed January through March will be reported by May 15; activities performed April through June reported by August 15; activities performed July through September reported by November 15; and activities performed October through December reported by February 15th.

6. Contractor must collect any payments available from other dental insurers including Medicare and private dental insurance for services provided to its members in accordance with section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D. 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.

12. Contractor is prohibited from recovering loss directly from the beneficiary.

I. Marketing

Contractor may promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of an entire city, an entire

county, or larger population segment in the Contractor's approved service area.

1. Contractor must comply with the marketing, branding, incentive, and other relevant guidelines and requirements established by MDHHS, State, and 42 CFR § 438.104.

2. Contractor may provide incentives, consistent with State law, to Enrollees that encourage healthy behavior and practices.

3. Contractor must secure MDHHS approval for all marketing materials prior to implementation.

    a. Upon receipt by MDHHS of a complete request for approval that proposes allowed Marketing practices and locations, MDHHS will provide a decision to the Contractor within 15 business days. The review clock will be tolled while the Contractor revises materials for re-submission.

    b. Contractor may repeatedly use marketing materials previously approved by MDHHS; Contractor must notify MDHHS of intent to repeat marketing materials/initiative and attest it is identical to the MDHHS-approved marketing prior to implementation.

4. Contractor must not provide inducements to beneficiaries or current Enrollees through which compensation, reward, or supplementary benefits or services are offered to enroll or to remain enrolled with the Contractor.

5. Direct marketing to individual beneficiaries not enrolled with the Contractor is prohibited. For purposes of oral or written marketing material, and contact initiated by the beneficiary, the Contractor must adhere to the following guidelines:

    a. Contractor may only provide factual information about the Contractor's services and contracted providers.

    b. If the Enrollee requests information about services, the Contractor must inform the Enrollee that all dental plans are required, at a minimum, to provide the same services as the Medicaid FFS.

    c. Contractor must not make comparisons with other Contractors.

    d. Contractor must not discuss enrollment, disenrollment, or Medicaid eligibility; the Contractor must refer all such inquiries to the State's enrollment broker.

    e. Contractor materials must not contain any assertion or statement that the Contractor is endorsed by CMS, the Federal or State government, or a similar entity.

6. Examples of allowed marketing locations and practices directed at the general population

    a. Newspaper articles

    b. Newspaper advertisements

    c. Magazine advertisements

    d. Signs

    e. Billboards

    f. Pamphlets

    g. Brochures

h. Radio advertisements

i. Television advertisements

j. Online advertising

k. Social media

l. Non-capitated plan sponsored events

m. Public transportation (e.g., buses, taxicabs)

n. Mailings to the general population

o. Health Fairs for Enrollees

p. Malls or commercial retail establishment

q. Community centers, schools, and daycare centers

r. Churches

7. Prohibited marketing locations/practices that target individual beneficiaries:

a. Local MDHHS offices

b. Provider offices, clinics, including, but not limited to, women, infants, and children (WIC) clinics, with the exception of window decals that have been approved by MDHHS.

c. Hospitals

d. Check cashing establishments.

e. Door-to-door Marketing

f. Telemarketing

g. Direct mail targeting individual Medicaid beneficiaries not currently enrolled in the Contractor's plan.

h. The prohibition of marketing in provider offices includes, but is not limited to, written materials distributed in the Providers' office.

i. Contractor must not assist providers in developing marketing materials designed to induce beneficiaries to enroll or to remain enrolled with the Contractor or not disenroll from another Contractor.

j. Contractor may provide decals to participating providers which can include the dental plan name and HKD logo. These decals may be displayed in the provider office to show participation with the dental plan. All decals must be approved by MDHHS prior to distribution to providers.

k. Contractor may provide an approved plan logo to participating Providers for use on Providers website to show participation with the dental health plan. All logos must be approved by MDHHS prior to distribution to Providers.

J. Health Fairs

Contractor may participate in health fairs that meet the following guidelines:

1. Organized by an entity other than a dental plan, such as, a local health department, a community agency, or a provider, for Enrollees and the general public.

2. Conducted in a public setting, such as a mall, a church, or a local health department. If the health fair is held in a provider office, all patients of the provider must be invited to attend.

3. Beneficiary attendance is voluntary; no inducements other than incentives approved by MDHHS under this Contract may be used to encourage or require participation.

4. Advertisement of the health fair must be directed at the general population, be approved by MDHHS, and comply with all other applicable requirements. A Contractor's name may be used in advertisements of the health fair only if MDHHS has approved the advertisement.

5. The purpose of the health fair must be to provide physical and oral health education and/or promotional information or material, including information about managed care in general.

6. No direct information may be given regarding enrollment, disenrollment, or Medicaid eligibility. If a beneficiary requests such information during the health fair, the Contractor must instruct the beneficiary to contact the State's enrollment broker.

7. No comparisons may be made between Contractors, other than by using material produced by a State Agency, including, but not limited to, the MDHHS Quality Check-Up.

K. Confidentiality

1. Contractor must comply with all applicable provisions of HIPAA; this includes the designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.

2. All Enrollee information, dental records, data, and data elements collected, maintained, or used in the administration of this Contract must be protected by the Contractor from unauthorized disclosure.

3. Contractor must provide safeguards that restrict the use or disclosure of information concerning Enrollees to purposes directly connected with its administration of the Contract.

4. Contractor must have written policies and procedures for maintaining the confidentiality of data, including, but not limited to, dental records and client information.

L. Dental Records

1. Contractor must ensure its providers maintain dental records in a detailed, comprehensive manner that conforms to professional dental practices, permits effective professional dental review, dental audit processes, and facilitates a system for follow-up treatment that permits effective patient care and quality review. Dental records must:

    a. Be signed and dated including entry and submission dates.

    b. Be retained for at least 10 years.

    c. Include Enrollee identification information.

    d. Include Enrollee personal/biographical data.

    e. Include provider identification.

f. Be legible.

g. Include past medical history, oral examinations, allergies, immunizations, diagnostic information, and emergency care.

h. Identify any current problems.

i. Include as applicable smoking, alcohol and/or substance abuse.

j. Include specialist referrals and results thereof.

k. Include any other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

2. Contractor must have written policies and procedures for the maintenance of dental records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

3. Contractor must have written plans for providing training and evaluating Providers' compliance with the recognized dental records standard.

4. Contractor must have written policies and procedures to maintain the confidentiality of all medical records.

5. Contractor must comply with applicable State and federal laws regarding privacy and security of dental records and protected health information.

6. MDHHS and/or CMS must be given prompt access to all Enrollees' dental records without written approval from an Enrollee before requesting an Enrollee's dental record.

7. Contractor must require network providers forward Enrollee’s dental records or copies of dental records to the new dental provider when an Enrollee changes dental provider within 10 business days from receipt of a written request.

M. Medical Loss Ratio

1. Contractor is subject to a minimum MLR. These provisions will apply on a contract specific basis and will only include revenue and expense experience applicable to members included under the contract.

2. Contractor must submit a consolidated MLR report for their Medicaid population for each MLR reporting year as directed by MDHHS and in accordance with 42 CFR 438.8(e), 42 CFR 438.8(f), 42 CFR 438.8(h), and 42 CFR 438.8(g). Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

3. Contractor must use the reporting tool provided by MDHHS for MLR reporting requirements for each fiscal reporting year of the contract.

4. Contractor must comply with the directives as outlined in the remainder of 42 CFR 438.8 and any MDHHS directives required to satisfy the MLR requirements outlined in this contract and other applicable federal and state statutes, policies, and/or guidance.

5. Contractor must meet the minimum Medical Loss Ratio requirement of 87 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 438.8((f)).

a. Incentive payments may only be included in MLR in as a benefit expense up to a limit of [3% x Total Premium Revenue]. Beyond this limit, incentive payments are not considered a benefit expense and should not be included in the numerator of the MLR Calculation. The inclusion of provider incentive payments in the numerator of the MLR calculation requires that provider incentive payments must meet the requirements of 42 CFR 438.3(i)(3). MDHHS requires the Contractor to retain documentation for each provider incentive arrangement in accordance with 42 CFR 438.3(i)(4)(i). MDHHS may approve an extension of this limit upon request on a case-by-case basis.

6. Failure of the Contractor to meet the Medical Loss Ratio requirements will result in the Contractor remittance of funds, within 90 days of MDHHS' notice to Contractor of its failure to meet the minimum MLR ratio, Contractor must remit back to MDHHS a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 87% multiplied by the revenue paid to the Contractor during the contract year. Rebates paid to MDHHS will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care Program.

7. Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR 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 reporting.

8. In any instance where MDHHS makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the state, the Contractor must:
   a. Recalculate the MLR for all MLR reporting years affected by the change.
   b. Submit a new MLR report meeting the applicable requirements.

XVI. Program Integrity

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

A. Fraud, Waste and Abuse **–** Contractor must implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste, and Abuse, including a mandatory compliance plan. The arrangements or procedures must include the following:

   1. Contractor's fraud, waste and abuse compliance program and plan (must include, at a minimum, all of the following elements):

      a. Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable Fraud, Waste, and Abuse requirements and standards under the Contract and all applicable Federal and State requirements.

         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:

(ii)i Duties and responsibilities of the compliance officer and Compliance Committees.

(ii)ii How and when employees will be trained.

(ii)iii Procedures for how employee reports of non-compliance will be handled.

(ii)iv Guidelines on how the compliance department will interactwith the internal audit department.

(ii)v Guidelines on how the compliance department will interact with the legal department.

(ii)vi Guidelines on how the compliance department will interact with the Human Resources department.

(ii)vii Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.

(ii)viii Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.

(ii)ix Conducting periodic reviews, at least annually, of the code ofconduct and the compliance policies and procedures.

(ii)x Procedures for the monitoring of compliance in Contractor and subcontractor systems and processes.

(ii)xi Procedures for monitoring of Potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.

(ii)xii Procedures for performing an investigation of targets selected for audit, including triage and review processes.

(ii)xiii The prohibition of any Contractor employee also being employed or contracted with one of their subcontractors, network providers, or providers.

(ii)xiv The prohibition of any managed care entity (MCE) staff employed in a program integrity capacity, or in an executive role, 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 advises the compliance officer and assists in the implementation 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 every quarter.

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.

(i)i Contractor must also determine under what circumstances it may be appropriate to train non-employee agents and contractors.

(i)ii 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.

(i)iii The initial compliance training for new employees must occur at or near the date of hire.

(i)iv Contractor must provide annual refresher compliance training that highlights compliance program changes or other new developments. The refresher training should re-emphasize Medicaid statutory, regulatory, and contractual requirements and the Contractor's code of conduct.

ii. 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 Noncompliance- Contractor must have mechanisms in place for employees and others to report suspected or actual acts of non-compliance.

(i)i In order to encourage communications, confidentiality and non-retaliation policies must be developed and distributed to all employees.

(i)ii Contractor must use e-mails, newsletters, suggestion boxes, and other forms of information exchange to maintain open lines of communication.

(i)iii A separate mechanism, such as a toll-free hotline, must be employed to permit anonymous reporting of non-compliance.

(i)iv 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.

(i)v 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.

ii. 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.

iii. 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 noncompliance, 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.

(i)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.

(i) iii In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.

(i)iiii 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.

ii. 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 XVI.B of this Contract for the method and timing of such reporting.

a. Contractor must have the right to recover overpayments directly from providers for the post payment evaluations initiated and performed by the Contractor.

i. 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 all 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 CFR § 438.608(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)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.

(i)ii Share referral via secure File Transfer Process (sFTP) using the Contractor's applicable MDHHS-OIG/AG-HCFD sFTP areas.

(i)iii Cooperate in presenting the fraud referral to the OIG and AG-HCFD at an agreed upon time and location.

(i)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:

a. Contact the subject of the investigation about any matters related to the investigation;

b. Enter into or attempt to negotiate any settlement or agreement regarding the

findings/overpayment; or

c. 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 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 through http://www.michigan.gov/fraud (File a Complaint - Medicaid Complaint Form). In addition, the Contractor must report all fraud, waste and abuse referrals made to MDHHS on their quarterly submission described in section 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 24.271 to 24.287 and MCL 24.301 to 24.306 for post payment evaluations conducted by MDHHS-OIG.

iv. Section XVI.A.2.d(i-iii) requirements must be included in the Contractor's:

(iv)i Provider enrollment agreements that must be in effect by January 1, 2019 and/or;

(iv)ii Provider manual – if the provider enrollment agreements in effect by January 1, 2019 require providers to adhere to the Contractor's provider manual.

v. Prior to initiating a post payment evaluation of a Contractor's network provider, MDHHS-OIG will:

(v)i Review the Contractor's quarterly submission information to determine whether the Contractor:

a. Performed a post payment evaluation of the provider in the previous 12-month period or;

b. Is currently performing post payment evaluation of the provider.

(v)ii Contact the Contractor to determine whether the Contractor 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.

a. 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.

b. 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:

(vi)i Limit the scope to dates of service that are at least one year old, and;

(vi)ii Notify the Contractor in writing and request applicable information from the Contractor. (Applicable information may include, but is not limited to; detailed Contractor post payment evaluation history with the provider, Contractor communication history with the provider, signed provider enrollment agreement for the provider, relevant Contractor policy, etc.) Contractor must provide MDHHS-OIG with the name of an individual that will act as the main Contractor contact for each post payment evaluation.

(vi)iii Determine if a claim-based audit or a sample/extrapolation post payment evaluation will be performed.

vii. If an overpayment is identified:

(vii)i MDHHS-OIG will provide written preliminary results to both the provider and Contractor. The provider will be permitted opportunity to submit additional information by the due date indicated on the preliminary results letter (normally 30 Days) to substantiate their claims.

(vii)ii MDHHS will review any additional information submitted by the provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306) to the Provider.

a. 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.

b. If the Provider does not appeal the final findings, MDHHS-OIG will proceed with recovering overpayments from the Contractor.

c. If the Provider appeals the final findings, MDHHS-OIG will not initiate recoupment from the Contractor until the appeal is resolved.

d. If the Provider appeals the final findings and the appeal is resolved in the State's favor, MDHHS-OIG will proceed with recovering the overpayment from the Contractor.

viii. Pursuant to 42 U.S.C. § 1396b, the State has one year from the date of discovering an overpayment before it must refund the federal portion of the overpayment to the federal government, regardless of recovery from the provider. Overpayments identified by MDHHS-OIG will be recovered from the Contractor via an MDHHS withhold or offset from the next capitation payment or primary push pay to the Contractor.

(viii)i. Contractor is responsible for the recovery of overpayments from their providers.

ix. Contractor must make all necessary adjustments (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 Appendix I. Contractor must notify MDHHS-OIG when the adjustments are complete.

(ix)i Failure to comply with the encounter correction timeliness standard will result in Contractor incurring liquidated damages as outlined in Appendix R.

g. Contractor must resolve outstanding encounter corrections in the timeframe designated within 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 XVI.B of this Contract for method and timing of such reporting.

5. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis.

a. Contractor must have methods for identification, investigation, and referral of suspected Fraud cases (42 CFR § 455.13, 455.14, 455.21).

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.

(i) ii Contractor may request a one-time extension in writing (e-mail) 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.

(i) iii Unless MDHHS-OIG has granted a written extension as described above, Contractor may be subject to contract remedies including but not limited to sanctions, penalties, and/or liquidated damages.

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).

(i)i The investigators in the unit must detect and investigate Fraud, Waste and Abuse by its Michigan Medicaid Enrollees and Providers. It must be separate from the Contractor's utilization review and quality of care functions. The unit can either be a part of the Contractor's corporate structure or operate under contract with the Contractor.

(i)ii Contractor must have at minimum one full-time equivalent (FTE) dedicated to Michigan Medicaid for every 100,000 Michigan Medicaid Enrollees or fraction thereof.

1. 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.

(i)(iii) 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.

1. 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).

      (i)i Contractor must omit any claims in the EOB file that are associated with sensitive services. The Contractor, with guidance from MDHHS, must develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

      (i)ii At a minimum, EOBs must be designed to address requirements found in 42 CFR § 455.20 and 433.116.

      (i)iii Contractor must ensure that the examined EOBs constitute a representative sample of EOBs from all typesof services and provider types.

      (i)iv The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS.

   ii. Contractor must track any complaints received from Enrollees and resolve the complaints according to its established policies and procedures based on the EOBs sent to Michigan Medicaid Enrollees. The resolution may be Enrollee education, Provider education or referral to MDHHS-OIG. The Contractor must use the feedback received to modify or enhance the EOB sampling methodology.

   iii. Contractor must report all EOB activities performed within the previous quarter to MDHHS-OIG. See Section XVI.B of this Contract for the method and timing of such reporting.

d. Data Mining Activities – Contractor must have surveillance and utilization control programs and procedures (42 CFR § 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. 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 XVI.B of this Contract for the method and timing of such reporting.

e. Preliminary Investigations – Contractor must promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste and Abuse. The Contractor must report all program integrity cases opened

within the reporting period to MDHHS-OIG. See Section XVI.B.of this Contract for the method and timing of such reporting.

All confirmed or suspected provider Fraud must immediately be reported to MDHHS-OIG.

Unless prior written approval is obtained from MDHHS-OIG, Contractor must not take any of the following actions as they specifically relate to Michigan Medicaid claims:

i. Contact the subject of the investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

f. Audit Requirements – Contractor must conduct risk-based auditing and monitoring activities of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste or Abuse. These audits should include a retrospective medical and coding review on the relevant claims.

In accordance with the Affordable Care Act, Contractor must promptly report overpayments made by Michigan Medicaid to the Contractor as well as overpayments made by the Contractor to a provider and/or Subcontractor. See Section XVI.B of this Contract for the method and timing of such reporting.

g. Prepayment Review – If the Contractor subjects a provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to the Contractor considering it for payment, as a result of suspected Fraud, Waste and/or Abuse, the Contractor must notify MDHHS-OIG in accordance with Section XVIB. 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 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 Appendix I. Contractor failure to comply with the encounter correction timeliness standard will result in Contractor incurring liquidated damages as outlined in Appendix R 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 P for the listing of notification forms and reports and their respective due dates:

   1. On a quarterly basis, the Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing the program integrity activities performed by the Contractor, as required by Section XVI.A of this Contract, during the previous quarter. This report must include any improper payments identified and 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 ofthe 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 encounters 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 Appendix D.

ii. Contractor failure to comply with the encounter correction timeliness standard will result in Contractor incurring liquidated damages as outlined in Appendix R, 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 liquidated damages 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 must also 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.

   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 XVI.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 Not Met for any Contract compliance review quarter where it has not initiated any program integrity activities, required by Section XVI.A of this Contract, during the previous quarter.

    b. 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.

    c. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not complied with the deliverable due dates.

    d. Contractor will receive a score of Met if they initiated program integrity activities as required by section XVI.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.

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. Contractor must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

1. 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.

2. Contractor and its providers, subcontractors and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section XVI of this Contract.

3. 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).

4. Contractor and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, dental and enrollee grievance and appeal records, base data in 42 CFR 438.5(c),), Medical Loss Ratio (MLR) reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610) available at the Contractor's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

    a. Access will be either through on-site review of records or by any other means at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time.

        i. Upon request, the Contractor, its provider or subcontractor must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring, or evaluation, including the provision of adequate space on the premises to reasonably accommodate MDHHS-OIG or other state or federal agency.

    b. Contractor must send all requested records to MDHHS-OIG within 30 Business Days of request unless otherwise specified by MDHHS or MDHHS rules and regulations.

    c. Records other than dental records may be kept in an original paper state or preserved on micromedia or electronic format. Dental records must be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and 10 years thereafter, unless an audit, administrative, civil, or criminal investigation or prosecution is in progress or audit findings or administrative, civil, or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

D. Provider Manual and Bulletins – Contractor must issue Provider Manual and Bulletins or other means of Provider communication to the providers of dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all Contract requirements are being met.

The Contractor may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

1. The Contractor's provider manual must provide all of its Providers with, at a minimum, the following information:

    a. Description of the Michigan Medicaid managed care program and covered populations;

    b. Scope of Benefits;

    c. Covered Services;

    d. Emergency services responsibilities;

    e. Grievance/appeal procedures for both Enrollee and provider;

    f. Medical necessity standards and clinical practice guidelines;

    g. The Contractor's policies and procedures including, at a minimum, the following information:

        i. Policies regarding provider enrollment and participation;

        ii. Policies detailing coverage and limits for all covered services;

        iii. Policies and instructions for billing and reimbursement for all covered services;

        iv. Policies regarding record retention;

        v. Policies regarding Fraud, Waste and Abuse;

        vi. Policies and instructions regarding how to verify beneficiary eligibility;

    h. Dentist responsibilities;

    i. Requirements regarding background checks;

    j. Other provider/subcontractors' responsibilities;

    k. Prior authorization and referral procedures;

    l. Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

    m. Records standards;

    n. Payment policies;

    o. Enrollee rights and responsibilities.

    p. Self-reporting mechanisms and policies as citied in XVI.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. Disclosure of Excess Payments to Contractor- Contractor and any subcontractors must report to MDHHS within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

G. 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 are currently debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

2. Contractor must not knowingly have a director, officer, partner or person with beneficial ownership of more than 5% of the Contractor's equity who is affiliated (as defined in the Federal Acquisition Regulation at 48 CFR § 2.101) with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

3. Contractor must not have a Network Provider, 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 (FAR) 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 (FAR) 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 FAR, 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 XVI.G of this contract.

H. Disclosure by Managed Care Entities: Information on Ownership and Control – Pursuant to 42 CFR § 455.104: MDHHS will review ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors.

1. Contractor must provide to MDHHS the following disclosures:

a. The identification of any person or corporation with a direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity (or, in the case of a Subcontractor's disclosure, 5% or more of the Subcontractor's equity);

b. The identification of any person or corporation with an ownership interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the Subcontractor equal to 5% of the Subcontractor's assets);

c. The name, address, date of birth and Social Security Number of any managing employee of the Managed Care organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e., member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

2. The disclosures must include the following:

a. The name, address, and financial statement(s) of any person (individual or corporation) that has 5% or more ownership or control interest in the Contractor.

b. The name and address of any person (individual or corporation) that has 5% or more ownership or control interest in any of the Contractor's Subcontractors.

c. Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor's employee such as a spouse, parent, child, or siblings; or is related to one of the Contractor's officers, directors or other owners.

d. Indicate whether the individual/entity with an ownership or control interest owns 5% or greater in any other organizations.

e. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

f. Date of birth and Social Security Number (in the case of an individual).

g. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Managed Care Organization or its Subcontractor.

3. The Contractor must terminate or deny network participation if a provider, or any person with 5% or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by MDHHS, within 30 Days when requested by MDHHS or any authorized federal agency.

4. Disclosures from the Contractor are due to MDHHS at any of the following times:

   a. When the Contractor submits a proposal in accordance with an MDHHS procurement process.

   b. When the Contractor executes the Contract with MDHHS.

   c. Upon renewal or extension of the Contract.

   d. Within 35 Days after any change in ownership of the Contractor.

   e. Upon request by MDHHS.

5. All required disclosures under this subsection must be made to MDHHS, the Secretary of the US Department of Health and Human Services and the Inspector General of the US Department of Health and Human Services in the format developed by the requestor. Failure to provide required information may lead to sanctions including withholding of capitation payment. Federal financial participation is not available for entities that do not comply with disclosures, therefore, MDHHS may withhold capitation from the Contractor for services provided during the period beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied.

I. Excluded Individuals and Entities – Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person. (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR § 455.104, 42 CFR § 455.106, and 42 CFR § 1001.1901(b)). Contractor must monitor its network providers for excluded individuals and entities by requiring its network providers be actively enrolled with the Michigan Medicaid Program.

1. Contractor must not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of

exclusion. The Contractor must immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

2. Contractor is prohibited from entering into any employment, contractual and control relationships with any excluded individual or entity.

3. Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (SSA section 1128A(a)(6)).

4. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5% or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR § 455.104(a), and 42 CFR § 1001.1001(a)(1)).

5. Contractor must immediately terminate all beneficial, employment, and contractual and control relationships with any individual or entity excluded from participation by MDHHS immediately.

J. Network Provider Medicaid Enrollment – Pursuant to 42 CFR § 438.602(b)(1), all network providers of the Contractor must enroll with the Michigan Medicaid Program.

1. The State will screen and enroll, and periodically revalidate all enrolled Medicaid providers.

2. Contractor must require all its network providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.

   a. Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification form the State that the network provider cannot be enrolled or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees.

3. Contractor must verify and monitor its network providers' Medicaid enrollment.

XVII. Emergency Management Plan

A. The Contractor shall submit to the Department a Business Continuity and Disaster Recovery (BC-DR) Plan specifying what actions the Contractor shall 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 shall 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 shall limit service interruption to a period of twenty-four (24) hours and shall ensure compliance with all contractual requirements. The records backup standards and the BC-DR plan shall be developed and maintained for the entire Contract period.

2. The BC-DR plan shall include a strategy for restoring day-to-day operations, including alternative locations for the Contractor to operate. The BC-DR plan shall maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction. The BC-DR plan shall be submitted to the Department annually. If the approved plan is unchangedfrom the previous year, the Contractor shall 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 afterthe 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 XVIII. Contractor Compliance Reviews, Non-Compliance, that outlines how the failure shall be resolved.

B. 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 appropriate member outreach as applicable, which may include daily communication efforts to reach members with mental health needs, high risk needs, and special healthcare needs. Communications include SMS text messaging and incoming calls to member and provider call centers.

    d. Contractor must conduct appropriate provider outreach as applicable, which may include daily communications to identify issues such as closures and re-openings, power outages, and evacuations.

C. At a minimum, the Contractor's BC-DR plan shall 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 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. The Contractor shall 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. 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 dental plan performance as determined by MDHHS.

2. MDHHS will determine if the Contractor meets contractual requirements and assess dental plan compliance as outlined in 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.

A. Contract Remedies, Sanctions and Penalties

1. MDHHS may utilize a variety of means to assure compliance with Contract requirements. MDHHS will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, MDHHS may impose civil money penalties, liquidated damages, late fees, performance penalties (collectively, "monetary sanction"), and other sanctions, on Contractor for Contractor's failure to substantially comply with the terms of this Contract.

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.

3. MDHHS will not impose any monetary sanction where the noncompliance is directly caused by the MDHHS's action or failure to act or where a force majeure delays performance by Contractor.

4. MDHHS may employ Contract remedies penalties, liquidated damages and/or sanctions to address any Contractor noncompliance with the Contract. Areas of noncompliance for which MDHHS may impose remedies penalties and sanctions include, but are not limited to, noncompliance with Contract requirements on the following issues:

    a. Marketing practices

    b. Member services

    c. Provision of medically necessary covered services

    d. Enrollment practices, including, but not limited to, discrimination on the basis of oral health status or need for dental services.

    e. Provider networks

    f. Provider payments

    g. Financial requirements including, but not limited to, failure to comply with physician incentive plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program.

    h. Enrollee satisfaction

    i. Performance standards included in **Appendix I** of this Contract.

    j. Misrepresentation or false information provided to MDHHS, CMS, providers, Enrollees, or potential Enrollees.

    k. Certificate of Authority

    l. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

5. MDHHS may utilize intermediate sanctions (as described in 42 CFR 438.700) that may include the following:

    a. Civil monetary penalties in the following specified amounts:

        i. A maximum of $25,000.00 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.

        ii. A maximum of $100,000.00 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

iii. A maximum of $15,000.00 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000.00 overall limit above).

iv. A maximum of $25,000.00 or double the amount of the excess charges, (whichever is greater) for charging copayments in excess of the amounts permitted under the Medicaid program. The State will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s).

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

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

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

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

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

g. The State will give the Contractor timely written notice for any intermediate sanctions that specifies the basis and nature of the sanction.

6. If intermediate sanctions or general remedies are not successful, or State determines that immediate termination of the Contract is appropriate, as allowed by Standard Contract Term provisions 23 and 24, the State may terminate the Contract with the Contractor.

    a. Contractor may be afforded a hearing before termination of a Contract under this section before termination 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, the State will notify Contractor Enrollees of such a hearing and allow Enrollees to disenroll, without cause, if they choose.

7. In addition to the sanctions described above, MDHHS may impose a monetary penalty of not more than $5,000.00 to a Contractor for each repeated failure on any of the findings of MDHHS Contract compliance review. This amount will be increased by $5,000.00 annually until the end of the contract period not to exceed $50,000.00.

B. Non-Compliance

Contractor agrees and understands that MDHHS may pursue tailored contractual remedies for noncompliance with this Contract. At any time and at its discretion, MDHHS may impose or pursue one or more remedies for each item of noncompliance 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. NONCs will not contain specific language regarding further compliance escalation or other consequences should the behavior/non-compliance continue. Contractor is required to acknowledge receipt of the notice and respond in accordance with contract requirements listed in this section (see B.3). No formal Corrective Action Plan is required.

6. Warning Letter: MDHHS may issue warning letters when the Contractor has already received a NONC, yet the problem persists. In addition, warning letters may be issued for a first offence for larger or more concerning issues. Unlike NONCs, warning letters will contain language about compliance enforcement action as well as the potential escalation of compliance enforcement action to the Contractor in the event the non-compliant performance continues. Contractor is required to acknowledge receipt of the notice and respond in accordance with contract requirements listed in this section (see B.3). No 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 or this Contract identified by MDHHS. In addition, CAPS may be issued for a first offence for larger or more concerning issues. The Contractor must submit a completed CAP to MDHHS within 30 Days from the date of receipt of MDHHS' notice of compliance violation 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/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. The Contractor must include in its Corrective Action Plan milestone dates for progress and an anticipated date of resolution for the issue. The contractor must provide the department with updates on the dates listed to ensure operational compliance with the CAP as proposed. The implementation of a CAP does not preclude the 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 Corrective Action Plan; or

    c. Require additional or different corrective action(s).

10. MDHHS' acceptance of a Corrective Action Plan 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 tailored remedies or pursuing other appropriate remedies for continued substandard performance.

11. Financial penalties will be assessed as outlined below regarding Corrective Action Plan submissions:

    a. $500 per calendar day for each day the Corrective Action Plan submission is late, or for each day the Contractor fails to comply with an accepted CAP as required by MDHHS.

    b. $2,000 for failure to provide an acceptable initial Corrective Action Plan as prescribed by MDHHS.

    c. If subsequent CAPs are determined deficient or delinquent MDHH will assess a $500 per calendar day penalty until an acceptable plan has been received as determined by MDHHS.

C. Liquidated Damages

If the Contractor breaches this Contract, MDHHS will be entitled to monetary damages 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. The Contractor will be assessed liquidated damages 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 may impose liquidated damages in addition to any sanctions imposed pursuant to Section. XVIII.A., Contract Remedies, Sanctions and Penalties.

1. The liquidated damages prescribed in this section are not intended to be in the nature of a penalty but are intended to be reasonable estimates of MDHHS' projected financial loss and damage resulting from the Contractor's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Contractor fails to perform in accordance with this Contract, the MDHHS may assess liquidated damages as provided in Appendix R.

2. If the Contractor fails to perform any of the services described in this Contract, MDHHS may assess liquidated damages for each occurrence listed in the table in Appendix R. 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 which 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.).

3. 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.

4. 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.

5. All liquidated damages imposed pursuant to this Contract, whether paid or due, will be paid by the Contractor out of administrative costs and profits.

6. 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 by U.S. mail and/or commercial courier service (hand delivery will not be accepted. This submission must be received by MDHHS within 21 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) must submit such dispute to the following mailing address:

        Michigan Department of Health and Human Services
        Attn: Bureau of Medicaid Care Management & Customer Service
        State Bureau Administrator
        P.O. Box 30479
        Lansing, MI 48933

    b. Waives any dispute not raised within 21 days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within 21 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 21 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).

c. Accepts the decision of the Bureau Director or his/her designee as final.

1.2 Reserved

2.0 Acceptance

I. Governing Body

A. Contractor Governing Body

Contractor must have a governing body to ensure adoption and implementation of written policies governing the operation of the Contractor.

B. Governing Body Chair

The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body.

C. Governing Body Procedures

Contractor must have written policies and procedures for governing body detailing, at a minimum, the following:

1. The length of the term for board members

2. Filling of vacancies

2.1 Acceptance, Inspection and Testing

The State will use the following criteria to determine acceptance of the Contract Activities: Section 16, of the Standard Contract Terms.

3.0 Staffing, Organizational Structure and Governing Body

3.1 Contractor Representative

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

3.2 Customer Service Toll-Free Number

Reserved.

3.3 Work Hours

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

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

I. Key Personnel

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

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

Contractor will not remove any Key Personnel from their assigned roles on this Contract without the prior written consent of the State. The Contractor's removal of Key Personnel without the prior written consent of the State is an unauthorized removal ("Unauthorized Removal"). An Unauthorized Removal does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation, or for cause termination of the Key Personnel's employment. Any Unauthorized Removal may be considered by the State to be a material breach of this Contract, in respect of which the State may elect to terminate this Contract for cause under Termination for Cause in the Standard Terms or apply Contractor sanctions in accordance with terms outlined in this Contract. It is further acknowledged that an unauthorized removal will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any unauthorized removal.

A. Key Personnel

1. Contractor must employ or contract with sufficient administrative staff to comply with all program standards. At a minimum, Contractor must specifically provide the following Key Personnel positions. Below are the Contractor's identified personnel for those positions: (See section 3.4.I.B for responsibilities)

    a. Executive Director/Chief Executive Officer (CEO) –

    b. Dental Director –

    c. Quality Improvement and Utilization Director –

    d. Chief Financial Officer (CFO) –

    e. Management Information System Director –

    f. Compliance Officer –

g. Member Services Director –

h. Provider Services Director –

i. Grievance and Appeals Coordinator –

j. Medicaid Liaison –

k. MIS Liaison –

l. Security Officer –

m. Privacy Officer –

n. 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 and conduct at least one implicit bias training annually as part of their DEI program. 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. Contractor must inform State in writing within seven days of vacancies or staffing changes for the personnel listed in A.1.a-f of this section.

5. Contractor must inform State in writing within 14 days of vacancies or staffing changes for the personnel listed in A.1.g-n, except 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.

6. Contractor must fill vacancies for the personnel listed in A.1.a-f of this section with qualified persons within six months of the vacancy unless an extension is granted by MDHHS.

7. Contractor must ensure that all requested and/or appropriate personnel attend or are made available during MDHHS onsite visitations with Contractor.

B. Key Personnel Responsibilities

1. Executive Director/Chief Executive Officer (CEO)

a. Full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract.

b. The Executive Director/CEO must be located in the State of Michigan.

c. Oversight of budget and accounting systems.

d. Responsible to the governing body for daily operations.

2. Dental Director

a. Licensed dental professional (DDS or DMD).

b. Must be located in the state of Michigan.

c. Responsible for all major clinical program components of the Contractor.

d. Responsibility to review medical care provided to Enrollees and medical aspects of provider contracts.

e. Ensure timely medical decisions, including after-hours consultation as needed.

f. Management of the Contractor's Quality Assessment and Performance Improvement Program.

g. Must ensure compliance with State and local reporting laws on communicable diseases, child abuse, and neglect.

3. Quality Improvement and Utilization Director

a. Full-time administrator who possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be any of the following:

i. Licensed dental professional (DDS or DMD).

ii. Certified quality professional, preferably with dental quality experience (i.e., Certified in Medical Quality (CMQ), Certified Professional in Healthcare Quality (CPHQ).

iii. Other licensed clinician as approved by MDHHS.

iv. Other professional possessing appropriate credentials as approved by MDHHS.

b. Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.

4. Chief Financial Officer

Full-time administrator responsible for overseeing the budget and accounting systems.

5. Management Information System Director

Full-time administrator who oversees and maintains the data management system to ensure the MIS is capable of valid data collection and processing, timely and accurate reporting, and

correct claims payments.

6. Compliance Officer

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

7. Member Services Director

   a. Coordination of communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate.

   b. Ensure sufficient member services staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

8. Provider Services Director

   a. Coordination of communications with subcontractors and other providers.

   b. Ensure sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.

9. Grievance/Appeal Coordinator

   Coordination, management, and adjudication of Enrollee and Provider grievances

10. Security Officer

    a. Development and implementation of security policies and procedures outlined in 45 CFR 164.

    b. Designated as the individual to receive complaints pursuant to security breaches in the Contractor's or State's policies and procedures.

11. Privacy Officer

    a. Development and implementation of privacy policies and procedures outlined in 45 CFR 164.

    b. Designated as the individual to receive complaints pursuant to breaches of the Contractor's privacy policies and procedures.

12. Medicaid Liaison

    Designated as the individual that manages communication between the Contractor's Medicaid subject matter personnel and MDHHS' staff.

13. MIS Liaison

    Designated as the individual that manages communication between the Contractor's MIS staff and MDHHS' technical staff.

14. SIU Manager/Liaison

    Designated as the individual that manages communication between the Contractor's SIU staff and both internal and external parties, including, but not limited to MDHHS and AG staff.

C. Support/Administrative Staff

Contractor must have adequate clerical and support staff to ensure that the Contractor's operation functions in accordance with all Contract requirements.

II. Organizational Structure

A. Contractor Administrative Linkages

Contractor's management approach and organizational structure must ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, grievance/appeal review, and management information systems.

B. Contractor Administrative Practices

Contractor must be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. Contractor must employ senior level managers with experience and expertise in dental care management and must employ or contract with skilled clinicians for dental management activities.

C. Financial Interest for Contractor Employees

Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its provider network or in the conduct of the Contractor's affairs. Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes managing employees, all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they ortheir families have a financial interest of 5% or more of the equity of the entity.

D. Disclosure of Financial Interest for Contractor Employees

Contractor must provide to MDHHS, upon request, a notarized and signed disclosure statement fully disclosing the nature and extent of any contracts or arrangements between the Contractor or a provider or other person concerning any financial relationship with the Contractor and any one of the following:

1. Providers – all contracted providers

2. Provider employees – directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity.

3. Contractor employees – director, officer, partner, managing employee, or persons with beneficial ownership of 5% or more of the entity's equity.

E. Contractor must notify MDHHS in writing of a substantial change in the facts set forth in the statement within 30 days of the date of the change. Information required to be disclosed in this section must also be available to the Department of Attorney General, Health Care Fraud Division.

F. Contractor's business must be located within the United States. Contractor's failure to meet this requirement is cause for termination as described in the Standard Contract Terms.

3.5 Organizational Chart and Governing Body

II. Organization Chart

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

3.6 Disclosure of Subcontractors

I. Subcontractor Disclosure Requirements

A. If the Contractor intends to utilize subcontractors, the Contractor must disclose the following per Appendix O – Subcontractor Template.

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

2. The relationship of the subcontractor to the Contractor.

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

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

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

II. Subcontractor Classifications

A. Administrative Subcontractors

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

1. Administrative subcontractors are classified by function.

   a. Type A administrative subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or other functions involving payment decisions.

   b. Type B Administrative Subcontractors perform administrative functions such as credentialing, utilization management, or case management.

   c. Type C administrative subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical necessity decisions. This type of administrative subcontractor includes, but is not limited to, identification card production and mailing services.

2. The Contractor must notify the State (see Contract Terms – Section 10 Subcontracting) of any new administrative subcontractors at least 21 days prior to the effective date of the contract with the administrative subcontractor.

3. MDHHS reserves the right to approve or reject Contractor's proposed use of an administrative subcontractor.

B. Provider (or Network Provider)

An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any Subcontractor, for the delivery of Covered Services to Enrollee

III. Flow-down of Contractor Responsibility

Except where specifically approved in writing by the State on a case-by-case basis, Contractor must flow-down the obligations in the subcontractor section of this Contract in all of its agreements with any subcontractors as specified by type of subcontract.

A. Contractor Full Responsibility

1. Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to subcontractors and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. If Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor must take corrective action, including when appropriate, revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

2. Contractor has full responsibility for the successful performance and completion of all Contract Requirements as specified in Schedule A, regardless of whether the Contractor performs the work or subcontracts for the services.

3. If any part of the work is to be subcontracted, the Contractor must provide MDHHS a list of subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted per section 3.6 Disclosure of Subcontractors.

4. Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract including the insurance provisions specified in the Standard Contract Terms, as applicable.

    a. Contractor must monitor subcontractor for compliance of all delegated Contract responsibilities, requirements and standards managed through the subcontractor.

5. Contractor is the sole point of contact for the State with regard to all contractual matters under this Contract, including payment of any and all charges for services included in Schedule A.

B. State Consent to Delegation

Contractor must not delegate any duties under this Contract to a subcontractor except as specified in section 3.6.

C. Subcontractor Bound to Contract

1. In any subcontracts entered into by Contractor for the performance contractor requirements, Contractor must require the subcontractor, to the extent of the contractor requirements to be performed by the subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State.

2. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State.

3. The management of any subcontractor is the responsibility of Contractor, and Contractor must remain responsible for the performance of its subcontractors to the same extent as if Contractor had not subcontracted such performance.

4. Contractor must make all payments to subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State is not obligated to direct payments for the contractor requirements other than to Contractor.

5. The State's written approval of any subcontractor engaged by Contractor to perform any obligation under this Contract will not relieve Contractor of any obligations or performance required under this Contract.

6. Contractor's agreement with its Subcontractors must:

    a. Require the Subcontractor comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Contract provisions.

    b. Require the Subcontractor agree that the state, CMS, the DHHS Inspector General, the Comptroller General or their agents have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the state.

    c. Require the Subcontractor make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Enrollees.

    d. Require the Subcontractor agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

    e. 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.

IV. 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 within 30 days of contract execution.
    c. All related party agreements must be disclosed on the Subcontractor Template, Appendix O.
    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.

4.0 Project Management

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

4.1 Meetings

I. Mandatory Administrative Meetings

A. Contractor Representatives

Contractor Representative must attend the following meetings:

1. QI Directors
2. CEO
3. Operations
4. The State may request other meetings, as it deems appropriate.

B. Contractor Collaboration

Contractor must attend other meetings as directed by MDHHS for the purpose of performing Contract requirements, improving workflows, and otherwise collaborating with MDHHS for benefit of Enrollees, Contractors, and the State.

4.2 Reporting

The Contractor must submit, to the MDHHS all reports outlined in this Contract, (**also see Appendix H**).

I. Data Reporting

A. Uniform Data and Information

1. The Contractor must provide MDHHS with uniform data and information as specified by MDHHS to measure the Contractor's accomplishments in the areas of access to care, utilization, oral health outcomes, Enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates.

2. Contractor must submit reports as specified in this section. Any changes in the reporting requirements will be communicated to the Contractor at least 30 days before they are effective unless State or federal law requires otherwise.

3. Contractor must submit all reports according to section 4.2 and provide MDHHS withadditional 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.

4. Contractor must cooperate with MDHHS in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols.

5. Contractor must develop and implement corrective action plans to correct data validity problems as identified by MDHHS.

II. Contractor Reports

A. Quality Assurance Reports

MDHHS may request reports or improvement plans addressing specific Contract performance issues identified through site visit reviews, EQRs, focus studies, or other monitoring activities conducted by MDHHS.

B. Financial Reports

1. Contractors must meet all financial reporting requirements and provide to MDHHS copies of the financial reports.

2. Contractor must submit annual and quarterly NAIC financial reports in the format required by MDHHS.

3. MDHHS may require monthly financial statements from the Contractor.

4. Contractor must submit data on the basis of which MDHHS:

   a. Certifies the actuarial soundness of capitation rates under § 438.4, including base data described in § 438.5(c) that is generated by Contractor.

   b. Determines the compliance of Contractor with the medical loss ratio requirement described in § 438.8.

   c. Determines that Contractor has made adequate provision against the risk of insolvency as

required under § 438.116.

5. Overpayment recoveries: The Contractor must provide an annual report of overpayment recoveries as required in § 438.608(d)(3).

6. The Contractor must submit audited financial reports specific to this Medicaid contract annually. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

C. Claims Reporting. Contractor must provide to MDHHS monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by MDHHS.

D. 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.

E. Provider Race/Ethnicity Reporting

Contractor must work with providers and MDHHS to collect and report the race/ethnicity of their contracted providers. Contractor will report the race/ethnicity of contracted providers to MDHHS within the specified timeline.

F. The Contractor must submit to the State the following data:

1. Documentation described in § 438.207(b) on which MDHHS bases its certification that Contractor has complied with MDHHS' requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206.

2. Network access plan as described in **Appendix E**.

3. Information on ownership and control described in § 455.104 of as governed by § 438.230.

G. 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.

H. 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.

I. Contract Compliance Review Reporting

1. Contractor must submit all reports as required by this Contract for Contract Compliance Review.

III. Release of Report Data

A. Written Approval

Contractor must obtain MDHHS's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its Enrollees other than as required by this Contract, statute, or regulations. The State is the owner of all data made available by the State to the Contractor or its agents, subcontractors, or representatives under the Contract.

B. Acceptable Use of State Data

Contractor will not use the State's data for any purpose other than providing the services to Enrollees covered by the Contractor under any contract or program, nor will any part of the State'sdata 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 ofthe Contractor, other than those on a strictly need-to-know basis, will have access to the State's data.

C. Acceptable Use of Personally Identifiable Data

1. Contractor must not possess or assert any lien or other right against the State's data. Without limiting the generality of this section, the Contractor must only use personally identifiable information as strictly necessary to provide the services to Enrollees covered by the Contractor under any contract or program and must disclose the information only to its employees on a strict need-to-know basis.

2. Contractor must comply, at all times, with all laws and regulations applicable to the personally identifiable information.

D. Acceptable Use of Contractor Data

The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this section, the State may use personally identifiable information only as strictly necessary to utilize the services and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State will comply, at all times, with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

5.0 Ordering

5.1 Authorizing Document

The appropriate authorizing document for services will be this Contract.

6.0 Invoice and Payment

I. General

Contracts are full-risk.

II. Payment Provisions

A. Fixed Price

Payment under this Contract will consist of a fixed reimbursement plan with specific monthly

payments based upon a unit price of a Per-Member Per-Month (PMPM) Capitated Rate. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. Capitation payments may only be made by MDHHS and retained by the Contractor for Medicaid-eligible enrollees.

B. 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 Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, due to its receipt of Medicaid premiums pursuant to the Contract. For purposes of this subsection, the full cost of the Health Insurer Fee includes both the Health Insurer Fee and the allowance to reflect the federal and State income tax. The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent capitation rate development methodology that incorporates relevant information which may include:

    a. The annual financial filings of all Contractors.

    b. Relevant Medicaid FFS data.

    c. Relevant Contractor encounter data.

2. MDHHS will not consider any claims paid by the Contractor to a Network Provider, Out-of-Network Provider, Subcontractor, or financial institution located outside the United States in the development of actuarially sound capitation rates.

C. Regional Rate

MDHHS will pay Contractor a Per-Member-Per-Month statewide rate. MDHHS at its discretion may adjust this rate on a regional basis if determined necessary by the State actuary.

D. Annual Review

MDHHS will annually review changes in implemented Medicaid Policy to determine the financial impact on HKD Program. Medicaid Policy changes reviewed under this section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in covered services, and modifications to Medicaid rates for covered services. If MDHHS determines that policy changes significantly affect the overall cost to the HKD Program, MDHHS will consider an adjustment of the fixed price per covered member to maintain the actuarial soundness of the rates.

E. Enrollment Files

MDHHS will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, MDHHS will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and MDHHS

will report payments to Contractors on a HIPAA-compliant 820 file. A process will be in place to ensure timely payments and to identify Enrollees the Contractor was responsible for during the month, but for which no payment was received in the service month. MDHHS may initiate a process to recoup capitation payments made to the Contractor for Enrollees who were retroactively disenrolled or who are granted retroactive Medicare coverage.

F. Contract Remedies and Performance Bonus Payments

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

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. 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.

G. 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. Contractor Performance Bonus

A. Performance Bonus

In accordance with MDHHS' continued commitment to quality improvement, MDHHS will withhold a percentage of the capitation payment from Contractor for performance of quality activities. During fiscal period 2025, MDHHS will withhold 1% of the approved Capitation Payment. MDHHS reserves the right to revise the capitation withhold percentage of each fiscal period in accordance with fiscal period quality activities. The withhold arrangement will not be renewed automatically. Participation in the withhold arrangement will not be conditional on the Contractor entering into or adhering to intergovernmental transfer agreements. These funds will be used for the Contractor

performance bonus awards, specified in Appendix J, and support program initiatives as part of the MDHHS quality strategy. Awards will be made to Contractors according to criteria established by MDHHS and in compliance with 42 CFR 438.6(b). The Contractor's performance will be measured during the rating period under the Contract in which the withhold arrangement is applied.

B. Criteria for Performance Bonus

The criteria for awards will include, but is not limited to, assessment of performance in quality of care, access to care, Enrollee satisfaction, and administrative functions. Each year, MDHHS will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

7.0 Health Insurance Portability and Accountability Act (HIPAA)

7.1 HIPAA Business Associate Agreement Addendum

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

APPENDIX A Regional Service Areas

Region	Counties
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

APPENDIX B Covered CDT Codes

COVERED CDT CODES		
All medically necessary services are covered, this is any service necessary to correct or ameliorate defects and physical and mental illnesses and conditions whether or not such services are covered under the State Plan. (See Appendix M-MSA 16-01)		
The Contractor is required to cover, at a minimum, all CDT codes covered by MDHHS Medicaid at a rate not lower than the established Medicaid reimbursement rate. Contractors may choose to provide additional services and higher reimbursement rates. The HKD program utilizes the CDT as the nationally accepted code set. All code definitions set by the CDT apply to Medicaid policy. It is the responsibility of the Contractor to comply with the most current MDHHS policy and code additions and communicate this information to its Network Providers.		
Code	**Short Description**	
D0120	Periodic Oral Evaluation	**DIAGNOSTIC**
D0140	Limit Oral Eval Problem Focus	
D0145	Oral Evaluation, Pt < 3yrs	
D0150	Comprehensive Oral Evaluation	
D0150	Comprehensive Oral Evaluation	
D0190	Screening Of A Patient	**PRE-DIAGNOSTIC**
D0191	Assessment Of A Patient	
D0210	Intraoral Complete Film Series	**DIAGNOSTIC**
D0210	Intraoral Complete Film Series	
D0220	Intraoral Periapical First	
D0230	Intraoral Periapical Ea Add	
D0240	Intraoral Occlusal Film	
D0270	Dental Bitewing Single Image	
D0270	Dental Bitewing Single Image	
D0272	Dental Bitewings Two Images	
D0272	Dental Bitewings Two Images	
D0273	Bitewings - Three Images	
D0273	Bitewings - Three Images	
D0274	Bitewings Four Images	
D0274	Bitewings Four Images	
D0330	Panoramic Image	
D1110	Dental Prophylaxis Adult	**PREVENTIVE**
D1110	Dental Prophylaxis Adult	

D1120	Dental Prophylaxis Child	
D1206	Topical Fluoride Varnish	
D1206	Topical Fluoride Varnish	
D1208	Topical App Fluoride Ex Varnish	
D1351	Dental Sealant Per Tooth	
D1352	Prev Resin Rest, Perm Tooth	
D1354	Interim Caries Arresting Medicament	
D1510	Space Maintainer Fixed Unilateral	
D1515	Fixed Bilat Space Maintainer	
D1550	Recement Space Maintainer	
D1555	Remove Fix Space Maintainer	
D1575	Distal Show Space Maintainer Fixed Unilateral	
D2140	Amalgam One Surface Permanent	**RESTORATIVE**
D2140	Amalgam One Surface Permanent	
D2150	Amalgam Two Surfaces Permanent	
D2150	Amalgam Two Surfaces Permanent	
D2160	Amalgam Three Surfaces Perma	
D2160	Amalgam Three Surfaces Perma	
D2161	Amalgam 4 Or > Surfaces Perm	
D2161	Amalgam 4 Or > Surfaces Perm	
D2330	Resin One Surface-Anterior	
D2330	Resin One Surface-Anterior	
D2331	Resin Two Surfaces-Anterior	
D2331	Resin Two Surfaces-Anterior	
D2332	Resin Three Surfaces-Anterior	
D2332	Resin Three Surfaces-Anterior	
D2335	Resin 4/> Surf Or W Incis An	
D2335	Resin 4/> Surf Or W Incis An	
D2390	Ant Resin-Based Cmpst Crown	
D2390	Ant Resin-Based Cmpst Crown	
D2391	Post 1 Srfc Resinbased Cmpst	
D2391	Post 1 Srfc Resinbased Cmpst	
D2392	Post 2 Srfc Resinbased Cmpst	
D2392	Post 2 Srfc Resinbased Cmpst	
D2393	Post 3 Srfc Resinbased Cmpst	
D2393	Post 3 Srfc Resinbased Cmpst	
D2394	Post >=4srfc Resinbase Cmpst	
D2394	Post >=4srfc Resinbase Cmpst	
D2710	Crown Resin-Based Indirect	
D2710	Crown Resin-Based Indirect	
D2712	Crown 3/4 Resin-Based Compos	

D2712	Crown 3/4 Resin-Based Compos	
D2910	Recement Inlay Onlay Or Part	
D2915	Recement Cast Or Prefab Post	
D2920	Re-Cement Or Re-Bond Crown	
D2930	Prefab Stnlss Steel Crwn Pri	
D2930	Prefab Stnlss Steel Crwn Pri	
D2931	Prefab Stnlss Steel Crown Pe	
D2933	Prefab Stainless Steel Crown	
D2933	Prefab Stainless Steel Crown	
D2934	Prefab Steel Crown Primary	
D2940	Protective Restoration	
D2950	Core Build-Up Incl Any Pins	
D2951	Tooth Pin Retention	
D2952	Post And Core Cast + Crown	
D2954	Prefab Post/Core + Crown	
D2999	Dental Unspec Restorative Pr	
D3110	Pulp Cap Direct	**ENDODONTIC**
D3110	Pulp Cap Direct	
D3220	Therapeutic Pulpotomy	
D3221	Gross Pulpal Debridement	
D3222	Part Pulp For Apexogenesis	
D3222	Part Pulp For Apexogenesis	
D3230	Pulpal Therapy Anterior Prim	
D3240	Pulpal Therapy Posterior Pri	
D3310	End Thxpy, Anterior Tooth	
D3310	End Thxpy, Anterior Tooth	
D3320	End Thxpy, Bicuspid Tooth	
D3320	End Thxpy, Bicuspid Tooth	
D3330	End Thxpy, Molar	
D3330	End Thxpy, Molar	
D3346	Retreat Root Canal Anterior	
D3346	Retreat Root Canal Anterior	
D3347	Retreat Root Canal Bicuspid	
D3347	Retreat Root Canal Bicuspid	
D3348	Retreat Root Canal Molar	
D3348	Retreat Root Canal Molar	
D3351	Apexification/Recalc Initial	
D3352	Apexification/Recalc Interim	
D3353	Apexification/Recalc Final	
D3410	Apicoectomy - Anterior	
D3410	Apicoectomy - Anterior	

D3421	Root Surgery Bicuspid	
D3425	Root Surgery Molar	
D3426	Root Surgery Ea Add Root	
D3430	Retrograde Filling	
D3999	Endodontic Procedure	
D4355	Full Mouth Debridement	**PERIODONTICS**
D5110	Dentures Complete Maxillary	
D5120	Dentures Complete Mandible	
D5130	Dentures Immediat Maxillary	
D5140	Dentures Immediat Mandible	
D5211	Dentures Maxill Part Resin	
D5212	Dentures Mand Part Resin	
D5213	Dentures Maxill Part Metal	
D5214	Dentures Mandibl Part Metal	
D5225	Maxillary Part Denture Flex	
D5226	Mandibular Part Denture Flex	
D5410	Dentures Adjust Cmplt Maxil	
D5411	Dentures Adjust Cmplt Mand	
D5421	Dentures Adjust Part Maxill	
D5422	Dentures Adjust Part Mandbl	
D5510	Dentur Repr Broken Compl Bas	
D5520	Replace Denture Teeth Complt	
D5610	Dentures Repair Resin Base	
D5620	Rep Part Denture Cast Frame	**PROSTHETICS**
D5630	Rep Partial Denture Clasp	
D5640	Replace Part Denture Teeth	
D5650	Add Tooth To Partial Denture	
D5660	Add Clasp To Partial Denture	
D5710	Dentures Rebase Cmplt Maxil	
D5711	Dentures Rebase Cmplt Mand	
D5720	Dentures Rebase Part Maxill	
D5721	Dentures Rebase Part Mandbl	
D5730	Denture Reln Cmplt Maxil Ch	
D5731	Denture Reln Cmplt Mand Chr	
D5740	Denture Reln Part Maxil Chr	
D5741	Denture Reln Part Mand Chr	
D5750	Denture Reln Cmplt Max Lab	
D5751	Denture Reln Cmplt Mand Lab	
D5760	Denture Reln Part Maxil Lab	
D5761	Denture Reln Part Mand Lab	
D5810	Denture Interm Cmplt Maxill	

D5811	Denture Interm Cmplt Mandbl	
D5820	Denture Interm Part Maxill	
D5821	Denture Interm Part Mandbl	
D5899	Removable Prosthodontic Proc	
D6930	Recement/Bond Part Denture	**IMPLANT SERVICES**
D7111	Extraction Coronal Remnants	
D7140	Extraction Erupted Tooth/Exr	
D7140	Extraction Erupted Tooth/Exr	
D7210	Rem Imp Tooth W Mucoper Flp	
D7210	Rem Imp Tooth W Mucoper Flp	
D7220	Impact Tooth Remov Soft Tiss	
D7220	Impact Tooth Remov Soft Tiss	
D7230	Impact Tooth Remov Part Bony	
D7230	Impact Tooth Remov Part Bony	
D7240	Impact Tooth Remov Comp Bony	
D7240	Impact Tooth Remov Comp Bony	
D7250	Tooth Root Removal	
D7250	Tooth Root Removal	
D7260	Oral Antral Fistula Closure	**ORAL SURGERY**
D7261	Primary Closure Sinus Perf	
D7270	Tooth Reimplantation	
D7310	Alveoplasty W/ Extraction	
D7320	Alveoplasty W/O Extraction	
D7471	Rem Exostosis Any Site	
D7472	Removal Of Torus Palatinus	
D7473	Remove Torus Mandibularis	
D7485	Surg Reduct Osseoustuberosit	
D7510	I&D Absc Intraoral Soft Tiss	
D7970	Excision Hyperplastic Tissue	
D7971	Excision Pericoronal Gingiva	
D7972	Surg Redct Fibrous Tuberosit	
D7999	Oral Surgery Procedure	
D9110	Tx Dental Pain Minor Proc	
D9223	General Anesthesia Each 15m	
D9243	Iv Sedation Each 15m	
D9248	Sedation (Non-Iv)	**ADJUNCTIVE SERVICES**
D9310	Dental Consultation	
D9420	Hospital/Asc Call	
D9930	Treatment Of Complications	
D9999	Adjunctive Procedure	

APPENDIX C Network Adequacy Standards- Timely Access Standards

Dental Plan Appointment and Timely Access to Care Standards	
Type of Care	**Length of time**
Emergency Dental Services	Immediately 24 hours/day, seven days per week
Urgent Care	Within 48 hours
Routine Care	Within 21 business days of request
Preventive Services	Within six weeks of request
Initial Appointment	Within eight weeks of request

APPENDIX D Time and Distance 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**
General Dentistry*	30	15	30	30	30	30	40	40	120	120	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
Endodontics	30	15	60	60	60	60	120	120	120	120	
Oral Surgery	30	15	60	60	60	60	120	120	120	120	
Periodontics	30	15	60	60	60	60	120	120	120	120	
Prosthodontics	30	15	60	60	60	60	120	120	120	120	
Pediatric Dentist	30	15	60	60	60	60	120	120	120	120	
To be counted in the 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). The ratio must reflect the unduplicated number of dentists in each county. If a dentist has multiple office locations and some offices are located in different counties, the Contractor may report the dentist in each county wherethe dentist practices 20 hours or more per week.											

Standards are based upon each county.

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

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 E Network Access Plan

Network Access Plan Requirements

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

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

3. The Network Access Plan, at a minimum, must contain the following:

    a. The Contractor's network, including how the availability of telemedicine or telehealth, e-visits, triage lines or screening systems or other technology is usedto meet network access standards.

    b. A description of the Contractor's ongoing efforts to ensure an adequate numberIHCPs, FQHCs and RHCs in its network.

    c. Time and distance tables of network general dentists and pediatric specialist coverage within the Contractor's service area. Contractor must provide Geo access maps upon MDHHS request, Contractor must also provide its internal analysis of provider ratios of the general dentistry and pediatric dental provider types to support the Contractor's ability to meet MDHHS' network adequacy andtime and distance standards. The analysis must include a review of the number of unique general dentists in the network and dental access points.

    d. The Contractor's procedures and time frames for making and authorizing referrals and prior authorizations, if applicable, within and outside its network.

    e. The Contractor's process for monitoring and assuring on an ongoing basis thesufficiency of its network to meet the oral health needs of the Contractor's enrolled population for all covered services within MDHHS' network adequacyand timely access standards.

    f. The factors used by the Contractor to build its provider network, including adescription of the network and the criteria used to select providers.

    g. The Contractor's efforts to address the needs of covered persons, including, butnot limited to, those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic, or complex, oral health conditions.

    h. The Contractor's methods for accessing the oral health care needs of the Contractor's Enrollees and their satisfaction with access to and availability ofservices.

i. The Contractor’s process for updating its provider directory.

j. The Contractor’s process for enabling Enrollees to choose dental providers.

k. The Contractor’s proposed plan for providing continuity of care in the event of new population enrollment, changes in service area, covered benefits, contracttermination between the Contractor and any of its participating providers including major health care groups, Contractor insolvency or other inability to continue operations.

l. The percentage of general dentistry providers accepting new patients specifyingthose with and without conditions/limitations. Contractors must address, in its plan, how it will work to increase network general dentists accepting new patients without conditions/limitations.

m. Describe rural service area strategies to maximize oral health network accessand availability for Enrollees.

n. For any requested or granted Provider Network Exceptions, Contractor must include how the Contractor will address and improve access and availability in

network gaps for the designated county and Provider specialty type needing anexception.

- Contractor must provide a report at the end of the fiscal Contractyear of affected Enrollee access to oral health services in areas granted the MDHHS access exception.
    - Report must include service delivery dates, length of time for requested appointments, location of where Enrollee received service, the distance of office locations from the Enrollee home.Report must exclude patient identifying information.

APPENDIX F Provider Directory Requirements

Provider Directory Listing Requirements Directory must give Enrollees the option to search Medicaid Providers by county.
Dental Professionals **(General Dentists and Specialists)** Provider Name, as well as any group affiliations Address Telephone Number Website URL (as applicable) Cultural and linguistic capabilities (including American Sign Language) Whether the Provider's office accommodates persons with physical disabilities (including offices and exam rooms) Specialty(ies) Board Certification Additional office locations Gender Hospital affiliation (if applicable) Office hours Whether accepting new patients (include any restrictions) Languages spoken other than English Whether the Provider has completed cultural competency training

APPENDIX G Stratified Data Requirements

Dental Plans must have the following data fields for operations:

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

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

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

* Dental Plans must have the ability to analyze data collected from the ADA CRA form (Age 0-6)completed and submitted by its Network Providers.

APPENDIX H Reporting Requirements

FISCAL YEAR 2025 REPORTING REQUIREMENTS FOR HKD 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 and provider file which are submitted electronically via the FTS.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
MLR Report	6/1/24	10/1/2022-9/30/2023	MDHHS MLR Template
Quarterly Submissions (Previous months)			
Financial	March 15 May 15 August 15 November 15	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	NAIC as reported to DIFS
Grievance/Appeal	January 30 April 30 July 30 October 30	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	MSA 131 (11/11), Grievance & Appeal Report
Third Party Recovery	February 15 May 15 August 15 November 15	October 1st -December 31st January 1st -March 31st April 1st -June 30th July 1st -September 30th	MDHHS Format Contract XV.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 2/18 due by 3/30/19	MSA 2009 (E)
Encounter Data	Not later than the 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/18 due by 2/15/20	837D Format
Provider Files	Friday before the last Saturday of each month	Submit all Providers contracted with the plan on the date of submission	Provider file layout and file edits distributed by MDHHS

APPENDIX I Performance Monitoring Standards

HEDIS® and CMS-416 PERFORMANCE MONITORING MEASURES*

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
CMS-416 Enrolled Children Receiving Any Dental Services	Any dental services are measured as the percentage of unduplicated children who received any dental service (CDT codes D0100-D9999) during the measurement period where unduplicated means that each child is counted only once even if multiple services were received.	39.4%	MDHHS Data Warehouse	Quarterly
CMS-416 Enrolled Children Receiving Dental Diagnostic Services	Following CMS Form-416 guidance, diagnostic dental services are measured as the percentage of unduplicated children who received a diagnostic dental service as defined by CDT codes D0100-D0999 (oral evaluation) where unduplicated means that each child is counted only once even if multiple services were received.	37.5%	MDHHS Data Warehouse	Quarterly
CMS-416 Enrolled Children Receiving Dental Preventive Services	Dental preventive services are measured as the percentage of unduplicated children who received a dental preventive service (CDT codes D1000-D1999) where unduplicated means that each child is counted only once even if multiple services were received.	35.8%	MDHHS Data Warehouse	Quarterly
CMS-416 Enrolled Children Receiving Dental Treatment Services	Dental treatment services are measured as the percentage of unduplicated children who received a dental treatment service (CDT codes D2000-D9999) where unduplicated means that each child is counted only once even if multiple services were received.	15.12%	MDHHS Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
CMS-416 Enrolled Children Receiving Sealant Services	Dental Sealant Services are measured as the percentage of unduplicated children who received a dental Sealant service (CDT codes D1351, D1352) where unduplicated means that each child is counted only once even if multiple services were received.	10%	MDHHS Data Warehouse	Quarterly
CMS-416 EnrolledChildren Receiving Oral Health Services by Non-Dentists	Dental Treatment Services are measured as the percentage of unduplicated children who received a dental treatment service (CDT codes D0190, D1206) where unduplicated means that each child is counted only once even if multiple services were received.	Informational Only	MDHHS Data Warehouse	Quarterly
CMS-416 EnrolledChildren Receiving Any Dental Services or Oral health Services by Non-Dentists	Dental Treatment Services are measured as the percentage of unduplicated children who received a dental treatment service (CDT codes D0100-D9999, D0190, D1206) where unduplicated means that each child is counted only once even if multiple services were received.	Informational Only	MDHHS Data Warehouse	Quarterly

DENTAL QUALITY ALLIANCE MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Utilization of Services	Percentage of all enrolled children under age 21 who received at least one dental service within the reporting year.	45%	Administrative	Annual
Dental/Oral Health Services: Preventive Services	Percentage of all enrolled children who are at "elevated" risk (moderate/high) who received a topical fluoride application and/or sealant within the reporting year.	Informational Only	Administrative	Annual
Dental/Oral Health Services: Treatment Services	Percentage of all enrolled children who received a treatment service within the reporting year.	Informational Only	Administrative	Annual
Dental/Oral Health Services: Sealant receipt on permanent 2nd molar	Percentage of enrolled children, who have ever received a sealant on a permanent second molar tooth (1) at least one sealant and all four molars (2) by the 15th birthdate.	Informational Only	Administrative	Annual
Dental/Oral Health Services: Sealant receipt on the permanent 1st molar	Percentage of enrolled children, who have ever received a sealant on a permanent first molar tooth (1) at least one sealant and all four molars (2) by the 10th birthdate.	14%	Administrative	Annual
Per Member per month cost of clinical services	Total amount that is paid on direct provision of care (reimbursed for clinical services) per member per month for all enrolled children during the reporting year.	Informational Only	Administrative	Annual

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Usual Source ofServices	Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years.	20%	Administrative	Annual
Care Continuity	Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	25%	Administrative	Annual

Dental and Oral Health Services Core Set Measures

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
Oral Evaluation, Dental Services (OEV-CH) DQA	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.	39.5%	Administrative	Annual
Topical Fluoride for Children (TFL-CH) DQA	The percentage of enrolled children aged 1 through 20 who received at least two (2) topical fluoride applications as dental services.	13%	Administrative	Annual

APPENDIX J Performance Bonus

PERFORMANCE BONUS FY25

This appendix considers plan performance on dental quality metrics. MDHHS will calculate performance rates using plan-submitted administrative data. Plans can earn up to 100 points. (**(1% withhold)**

Performance Area and Point Allocation	Total Maximum Points	Reporting Period	Due Date
Emergency Dental Follow-Up			
Emergency dental follow-up • DHP met 50% of benchmark for follow-up in clinics with a **diagnostic visit** within 90 days after the emergency visit. **(2 points)** • DHP met 50% of benchmark for follow-up in clinics with a **preventive visit** within 90 days after the emergency visit. **(5 points)**	5	Oct 2024 to Sep 2025	MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.
Outreach in Non-Utilizers			
Outreach & Dental Home Facilitation to Non-utilizers in plan. Target Rate: 20%	5	Oct 2024 to Sep 2025	Dental plans report the data on the last Thursday of each month based on the information retrieved from the requested files.-The updated data will be submitted to MDHHS by Jan 15, 2026
CAHPS Survey:			
CAHPS: Dental Access measure Benchmark: 75% **(5 Points)**	5	Beneficiaries enrolled in Oct 2023 to Sept. 2024	Withhold scoring is done on data extracted from the CAHPS survey administered by HSAG approximately, Jan-March of 2025 to be published in spring/summer of 2025.

Performance Area and Point Allocation	Total Maximum Points	Reporting Period	Due Date
Utilization			
Utilization in Non-Utilizers after Outreach: # of Claims and Encounters (any dental CDT code) in Non-Utilizers / Total Non-utilizers in plan *100 Target rate: 30%	10	Oct 2024 to Sep 2025	Dental plans report the data on the last Thursday of each month based on the information retrieved from the requested files. The updated data will be submitted to MDHHS by Jan 15, 2026.
Racial and or Ethnic Disparity Measure in Dental Diagnostic Utilization: • Identification of statistically significant disparity in dental diagnostic services (if present) between the white population to all other races and/or ethnicities in the plan for baseline reporting. (No points)	N/A	Oct 2024 to Sep 2025	MDHHS will extract the data for this measure at the end of Dec 2025/beginning of Jan 2026.
Sealant Measures • **# of children receiving a dental sealant (CMS 416 12d measure)** Benchmarks: ▪ 12% (**5 points)** ▪ 10% (**2 points)** • **Sealant measure on 1st molar (Core Set measure)[1]** Benchmark**:** 14% minimum **(5 points)**	5 5	Oct 2024 to Sep 2025 Oct 2024 to Sep 2025	MDHHS will extract the data for this measure at the end of Dec 2025/beginning of Jan 2026. MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.
Dental Utilization in Foster Care Children			
# of oral evaluations in foster care children aged above 1 year of age in the reporting period: Benchmarks: • 30% **(2 points)** • 40% **(5 points)**	5	Oct 2024 to Sep 2025	Dental plans report the data on the last Thursday of each month. The updated data will be submitted to MDHHS by Jan 15, 2026.
# of preventive utilization in foster care children aged from 0-20 years of age in the reporting period: Benchmarks: • 52% **(2 points)** • 80% **(5 points)**	5	Oct 2024 to Sep 2025	Dental plans report the data on the last Thursday of each month. The updated data will be submitted to MDHHS by Jan 15, 2026. .

Performance Area and Point Allocation	Total Maximum Points	Reporting Period	Due Date
Outcome Measures			
Oral Evaluation, Dental Services (OEV-CH) - DQA measure Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year. Benchmarks: • 39.5% **(2 points)** • 45% **(5 points)** • 50% **(10 points)**	10	Oct 2024 to Sep 2025	MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.
Topical Fluoride for Children (TFL-CH) - DQA measure The Percentage of enrolled children ages 1 through 20 who received at least two (2) topical fluoride applications as dental services. Benchmarks: • 13% **(5 points)** • 14% **(10 points)**	10	Oct 2024 to Sep 2025	MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.
Usual Source of Services - DQA measure The Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years. Benchmarks: • 25% (5 points) • 23% (3points) • 20% (2 points**)**	5	Oct 2023 to Sep 2024 and Oct 2024 to Sep 2025* *This is FY measurement	MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.
Care Continuity - DQA Measure The Percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	5	Oct 2023 to Sep 2024 and Oct 2024 to Sep 2025*	MDHHS will extract the data for this measure at the end of Dec 2025/ beginning of Jan 2026.

Benchmarks: • 25% **(2 points)** • 28% **(3 points)** • 30% **(5 points)**		*This is FY measurement	
Value-Based Payment (VBP) *Provider recruitment in a region selected by Dental Health plans for VBP. Points for meeting the goals mentioned below and reporting to MDHHS.*			
Provider Recruiting and Reporting for VBP 1. Model 2b, 2c or higher (No points) **2. Provider participation:** Benchmarks: • 30% **(2 points)** • 40% **(5 points)** **3. Provider payment (big numerator)** Benchmarks: • 10% of total provider payment **(2 points)** • 20% of total provider payment **(5 points)** **4. Beneficiary participation (members assigned to the dentist):** Benchmark: • 20% **(5 points)** **5. Provider Participation** BSC Region 2 only Contractor must have an APM arrangement with every dental provider in their network for foster care children in place by the end of FY25. Benchmark: 100% provider participation in BSC Region 2: **(10 points).**	25	Oct 2024 to Sept 2025	Dental plans report the data on the last Thursday of each month. The final updated report will be due on Jan 15th, 2026. Template provided. Dental plans will submit a list of their providers enrolled in APM in BSC Region 2. Final updated report on Jan 15th, 2026.
Total Points	**100**		

[1] **The Child Core Set includes a range of children's quality measures encompassing both physical and mental health and oral health reported to CMS. 2024 Core Set of Children's Health Care Quality Measure for Medicaid and CHIP (Child Core Set)**

PERFORMANCE MONITORING (DHPs are expected to work on the following priorities based on the contractual requirements. These additional expectations are set forth by MDHHS to ensure quality dental care for all beneficiaries and will not be awarded points for calculation of withhold bonus.)	Points Earned for Withhold bonus
Performance Improvement Project	N/A
Topic: Focus on a disparity in a region (clinical PIP) and a Non-Clinical PIP (Topic TBD)	
Compliance Review	N/A
CAHPS SURVEY	N/A
Access to Dental Care	
Care from Dentists and Staff	
Customer Service	
Dental Care Rating	
Dental Plan Rating	
Consumer Guide Dental Health Plan Rating	N/A
Encounter Data Validation (EDV)	N/A

Performance Measure Validation (PMV)	N/A
FOCUS STUDY	N/A
TOTAL POINTS EARNED	N/A

APPENDIX K Performance Monitoring Standards

FINANCIAL MONITORING STANDARDS

Reporting Period	Monitoring Indicator	Threshold	Dental Plan Action	MDHHS Action
Quarterly Financial	Working Capital	Below minimum	Notify MDHHS within 10 business or release of quarterly financial. 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	Notify MDHHS within 10 business or release of quarterly financial. Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.	Freeze auto assigned Enrollees.
Annual Financial	Medical Loss Ratio	87%	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 87% multiplied by the revenue paid to the Contractor during the contract year. 2. Must submit to MDHHS a Corrective Action Plan that describes its plan to come into compliance with the threshold requirement inclusive of Contractor tasks and timeframes.	Below 87%: Remit difference to MDHHS and Corrective Action Plan
Annual Financial Statement	Risk Based Capital (RBC)	150-200% RBC	Notify MDHHS within 10 business or release of quarterly financial. Submit written business plan within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.	Limit enrollment or freeze auto assigned Enrollees.
Annual Financial Statement	RBC	100-149% RBC	Notify MDHHS within 10 business or release of quarterly financial. Submit written business plan (if not previously submitted) within 30 days of MDHHS notification that describes actions including timeframe to restore compliance.	Freeze all enrollments.
Annual Financial Statement	RBC	Less than 100% RBC	Develop transition plan	Freeze all enrollments. Terminate contract.

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

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

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [3, 8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal-risk ssessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/ vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.

9 At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

10 Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.

11 Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.

12 Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.

13 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

14 Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

APPENDIX M MSA 16-01 EPSDT Covered Services

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-01

Distribution: All Providers

Issued: January 15, 2016

Subject: Clarification of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Covered Services and Definition of "Medically Necessary"

Effective: Immediately

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to provide clarification of covered services and to define "medically necessary" as it pertains to the EPSDT program. The intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions whether or not such services are covered under the state plan.[1] State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age.

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

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

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

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

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

be covered in the in the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually. Prior authorization is not required for medically necessary screenings.[3]

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

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

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

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

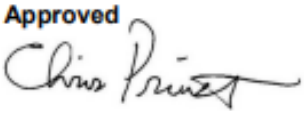
Manual Maintenance

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

Questions

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

Approved



Chris Priest, Director
Medical Services Administration

References

1. Social Security Act of 1935 (Section 1905(a)), 42 U.S.C. §1396d(a)(13). (1967). Retrieved October 9, 2015. www.ssa.gov/OP_Home/ssact/title19/1905.htm and www.law.cornell.edu/uscode/text/42/1396d.

2. Policy Statement: Essential Contractual Language for Medical Necessity in Children. (2013). American Academy of Pediatrics. *Pediatrics*, 132(2). Retrieved October 9, 2015 from http://pediatrics.aappublications.org/content/132/2/398.full.pdf.

3. EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. (2014). Centers for Medicare & Medicaid Services. Retrieved October 9, 2015 from www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf.

4. Clarification of Medicaid Coverage of Services to Children with Autism. (2014). CMCS Informational Bulletin. Centers for Medicare & Medicaid Services. Retrieved October 9, 2015 from www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf.

APPENDIX N HIPAA Business Associate Agreement Addendum

HIPAA BUSINESS ASSOCIATE AGREEMENT ADDENDUM

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

RECITALS

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

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

C. As part of the HIPAA Rules, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specificrequirements with Associate prior to the disclosure of Protected Health Information, as set forth in, but not limited to, 45 CFR Parts 160 and 164 and the HITECH Act, and as otherwise contained in this Addendum.

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. Definitions.
   a. Except as otherwise defined herein, capitalized terms in this Addendum have the same meaning as those terms under HIPAA, theHITECH Act, and the HIPAA Rules.
   b. "Agent" has the same meaning given to the term under the federal common law of agency.
   c. "Agreement" means the Contract and this Addendum, as read together.
   d. "Breach" means the acquisition, access, Use or Disclosure of Protected Health Information or Personal Identifying Information in a manner not permitted under the Privacy Rule or the Michigan Identify Theft Protection Act, as applicable, which compromises the security or privacy of such information.
   e. "Contract" means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added. Contract also includes all amendments and addendums to the original contract, both effective before and effective after the date of this Addendum.
   f. "Designated Record Set" has the same meaning as the term under 45 CFR §164.501.
   g. "Disclosure" means, the release, transfer, provision of access to, or divulging of Protected Information in any manner outside theentity holding the information.
   h. "Electronic Health Record" has the same meaning as the term under Section 13400 of the HITECH Act.
   i. "Electronic Protected Health Information" or "Electronic PHI" has the same meaning as the term under 45 CFR §160.103, limitedto the information created, received, maintained or transmitted by Associate on behalf of CE.
   j. "HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
   k. "HITECH Act" means The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, specifically Division A: Title XIII Subtitle D—Privacy, and its corresponding regulations as enacted under the authority of the Act.
   l. "Identity Theft Protection Act" means Public Act 452 of 2004, MCL 445.61, *et seq*.
   m. "Individual" has the same meaning as the term under 45 CFR §160.103 and includes a person who qualifies as a personalrepresentative in accordance with 45 CFR §165.502(g).
   n. "Personal Identifying Information" or "PII" has the same meaning as the term Section 3(q) of the Identity Theft Protection Act.

o. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164,Subparts A and E.

p. "Protected Health Information" or "PHI" has the meaning given to the term under the Privacy Rule, 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Associate on behalf of CE.

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

r. "Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction ofProtected Information or interference with system operations in an information system.

s. "Security Rule" means the Standards for Security of Electronic Protected Health Information at 45 CFR Part 160 and Subparts Aand C of Part 164.

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

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

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

2. Obligations and Activities of Associate.

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

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

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

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

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

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

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

ii. Providing a level and scope of security that is at least comparable to the level and scope of security established by the National Institute of Standards and Technology (NIST) in NIST 800-53, Recommended Security Controls for Federal Information Systems, Annex 2: Consolidated Security Controls-Moderate Baseline. The oldest acceptable version is the most recently approved version of NIST that has been approved for 6 months or more; however, Associate is

encouragedto adopt newly approved versions of NIST as soon as practicable. If Associate chooses to use the Control Objectives for Information and Related Technology (COBIT), Information Systems Audit and Control Association (ISACA), or International Organization for Standardization (ISO) standards, Associate must demonstrate and document how each aspect of the chosen standard comports with the applicable version of NIST and make such documentation available to CE upon request. If Associate uses a standard other than those described in this subsection, Associate must demonstrate and document how each aspect of the chosen standard comports with the appropriate version of NIST and present to CE for review and approval. Additionally, whichever standard is chosen must comport with HIPAA Rules, including specifically the Security Rule and Privacy Rule.

iii. Achieving and maintaining compliance with the Michigan Information Technology Security Policies set forth by the Officeof Michigan Cyber Security and Infrastructure Protection.

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

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

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

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

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

iii. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a Security Incident or a Use or Disclosure of Protected Information in violation of the requirements of this Addendum. Associate must take: (a) prompt corrective action to cure any such violation and (b) any other action pertaining to suchunauthorized Use or Disclosure required by applicable federal and state laws and regulations.

d. Responsibility for Notifications. If the cause of a Breach of Protected Information is attributable to Associate or its Agents or Subcontractors, Associate is responsible for all required reporting and notifications of the Breach as specified in and in accordance with Section 13402 of the HITECH Act and

the Identity Theft Protection Act, as applicable, unless CE notifies Associate in writing that CE intends to be responsible for said reporting and notifications. In all cases, CE's authorized representative shall approve the time, manner, and content of any such notification and its approval must be obtained before thenotification is made. In the event of such Breach, and without limiting Associate's obligations of indemnification as further described in this Addendum, Associate must indemnify, defend, and hold harmless CE for any and all claims or losses, includingreasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from CE in connection with the occurrence.

e. Associate's Agents and Subcontractors. If Associate uses one or more Subcontractors or Agents to provide services under the Agreement, and such Agents or Subcontractors receive or have access to Protected Information, each Subcontractor or Agent must sign an agreement with Associate containing substantially the same provisions as this Addendum and in conformance with45 CFR §164.504(e)(2), and to assume toward Associate all of the obligations and responsibilities that the Associate, by this Addendum, assumes toward CE. Associate agrees to provide said Agents or Subcontractors PHI in accordance with the HIPAARules, the HITECH Act, and PII in accordance with applicable federal and state law and must: (i) implement and maintain sanctions against Subcontractors and Agents that violate such restrictions and conditions; and (ii) mitigate, to the extent practicable, the effects of any such violation.

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

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

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

i. Access to Records and Internal Practices. Unless otherwise protected or prohibited from discovery or Disclosure by law, Associate must make its internal practices, books, and records, including policies and procedures (collectively, Compliance Information), relating to the Use or Disclosure of PHI and PII and the protection of same, available to CE or to the Secretary of DHHS (Secretary) for purposes of the Secretary determining CE's compliance with the HIPAA Rules and the HITECH Act. Associate shall have a reasonable time within which to comply with requests for such access, consistent with this Addendum. Inno case shall access be required in less than five (5) business days after Associate's receipt of such request, unless otherwise designated by the Secretary.

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

k. Compliance.

   i. To the extent that Associate carries out one or more of CE's obligations under the HIPAA Rules, Associate must comply with all requirements that would be applicable to CE.

   ii. Associate must honor all restrictions consistent with 45 CFR §164.522 that CE or the Individual makes Associate awareof, including the Individual's right to restrict certain Disclosures of PHI to

a health plan where the Individual pays out of pocket or in full for the healthcare item or service, in accordance with Section 13405(a) of the HITECH Act.

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

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

n. Destruction of Protected Information. Associate must implement policies and procedures for the final disposition of Protected Information, including electronic PHI, and the hardware and equipment on which it is stored, including but not limited to, removal before re-Use, in accordance with the Security Rule, the HITECH Act, and other applicable laws relating to the final disposition ofProtected Information.

o. Audits, Inspection, and Enforcement. Within ten (10) days of a written request by CE, Associate and its Agents or Subcontractors must allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the Use or Disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE or Associate shall execute a nondisclosure agreement, if requested by Associate or CE. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under this Addendum. If Associate is the subject of an audit, Contract compliance review, or complaint investigation by DHHS that is related to the performance of its obligations pursuant to this Addendum, Associate must notify CE and provide CE with a copy of any PHI that Associate provides to DHHS concurrently with providing such information to DHHS. If,as a result of an audit or other investigation of Associate, DHHS assesses any civil penalties, Associate shall pay such penalties.

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

q. Reserved.

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

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

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

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

3. Obligations of CE.

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

b. Notice of Limitations and Changes. CE must notify Associate of any limitations in its notice of privacy practices in accordance with45 CFR §164.520, or any restriction to the Use or Disclosure of PHI that CE has agreed to in accordance with 45 CFR §164.528, to the extent that such limitation may affect Associate's Use or Disclosure of PHI. CE must also notify Associate of any changes in, or revocation of, permission by Individual to Use or Disclose PHI of which it becomes aware, to the extent that such changes may affect Associate's Use or Disclosure of PHI.

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

5. Termination.

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

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

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

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

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

c. Reserved.

d. Effect of Termination.

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

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

6. Reserved.

7. No Waiver of Immunity. No term or condition of this Addendum shall be construed or interpreted as a waiver, express or implied, of any ofthe immunities, rights, benefits, protection, or other provisions of applicable laws, including the Michigan Governmental Immunity Act, MCL691.1401, *et seq*., the Court of Claims Act, MCL

600.6401, *et seq*., the Federal Tort Claims Act, 28 U.S.C. 2671, *et seq.*, or the common law, as applicable, as now in effect or hereafter amended.

8. Reserved.

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

10. Reserved.

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

12. Assistance in Litigation or Administrative Proceedings. Associate must make itself, and any Subcontractors, employees or Agents assisting it in the performance of its obligations under this Addendum available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against a party, its directors, officers or employees,departments, agencies, or divisions based upon a claimed violation of HIPAA, the HITECH Act, the HIPAA Rules, the Identity Theft Protection Act, or other laws relating to security and privacy of Protected Information, except where the other party or its Subcontractor, employee or Agent is a named adverse party.

13. No Third-Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

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

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

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

17. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate's obligations under Section 2(d) (Responsibility for Notifications), Section 2(u) (Indemnification), Section 5(d) (Effect of Termination), Section 12 (Assistance in Litigation orAdministrative Proceedings), Section 13 (No Third Party

Beneficiaries), and applicable record retention laws shall survive termination of this Agreement and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate.

18. Representatives and Notice.

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

b. Notices. Except as otherwise provided in this Addendum, all required notices shall be in writing and shall be hand delivered orgiven by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

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

Business Associate Representative:

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

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

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

Associate	**Covered Entity**
	Michigan Department of Health and Human Services
By: _____	By: _____
Print Name: _____	Print Name: Christine Sanches
Title: _____	Title: Director, Bureau of Budgeting and Purchasing

APPENDIX O Subcontractor Template

SUBCONTRACTOR TEMPLATE

Provider Subcontractors **Dental Plan:**
Contract Authority:

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

Due Date: January 15

Category I Administrative A, B or C	Notify MDHHS at least 21 calendar days prior to the effective date
Full Name of Subcontractor	
Related Party? Yes/No	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

Full Name of Subcontractor	
Related Party? Yes/No	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

Category I Administrative A, B or C	Notify MDHHS at least 21 calendar days prior to the effective date
Full Name of Subcontractor	
Related Party? Yes/No	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

Full Name of Subcontractor	
Related Party? Yes/No	
Subcontractor Street Address	
City, State, Zip Code	
Phone	
State Administrative A, B or C Description of Work to be Subcontracted	
Contact Person Name	
Contact Person Phone Number	
Contract Effective Date	
MDHHS Original Notification Date	

APPENDIX P Contractor Compliance Review

CONTRACTOR COMPLIANCE REVIEW-Program Integrity

Report Reference	Due Date	Period Covered
Annual Submissions		
Annual Program Integrity Report for Michigan Medicaid	January15	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)		
	Due Date	
Quarterly EOB Log	February 15 May 15 August 15 November 15	October 1 -December 31 January1 –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 January1 –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 January1 –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 January1 –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 January1 –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 January1 –March 31 April 1 -June 30 July 1 –September 30

Quarterly Provider Disenrollment Log		February 15 May 15 August 15 November 15	October 1 -December 31 January1 –March 31 April 1 -June 30 July 1 –September 30
Quarterly Provider Prepayment Review Placement Log		February 15 May 15 August 15 November 15	October 1 -December 31 January1 –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 MDDHHS-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 Q Electronic File Description

Electronic File Description – Dental Health Plans
Files transferred via MDHHS File Transfer Service

File Name	File Number	Description	Sending Organization	Receiving Organization	Frequency[1]
DHP Provider File	5937	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	HIPPA transaction that reflects errors in the 5476 individual Encounter transactions submitted by the Contractor	Department CHAMPS	Contractor	Daily; response file
834 Audit File	5015	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
837D Encounter File	5476	HIPAA transaction that identifies healthcare claims for dental claims or 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
Paid Claims History Request File	5656	Proprietary text file containing the Member IDs of Enrollees for which integrated care information is requested	Contractor	MDHHS Data Warehouse (DCHBULLB)	On Demand
Paid Claims History Return File	6009	Binary zipped file containing the claim and encounter data for the requested Contractor Enrollees.	MDHHS Data Warehouse (DCHBULLB)	Contractor	On Demand
834 Daily File	5629	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 File 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	Weekly

[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 R Liquidated Damages

Liquidated Damages		
#	**FINDING**	**DAMAGES**
1	Contractor failure to comply with encounter data submission requirements as described in this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by MDHHS). (Appendix I)	**$6,250** per occurrence.
2	Contractor failure to comply with timely encounter data correction as described in this Contract. (Appendix I)	**$500** per day, per occurrence.
3	Contractor failure to address or resolve errors with individual encounter records in a timely manner as required by MDHHS. (Section 1.1.,XVI.B1)	**$500** per day.
4	Contractor failure to submit Contract compliance review submission/report by defined due date (Section 4.2., II.J)	**$1,000** per day per occurrence
5	Contractor failure to submit a deliverable for MDHHS-OIG provider referral or member referral.	**$250** per day per occurrence

APPENDIX S Definitions

TERM	DEFINITION
The terms used in this Contract must be construed and interpreted as defined below unless the Contract otherwise expresslyrequires a different interpretation:	
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)
Adverse Benefit Determination	An action or inaction by the Contractor including the following: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for service. (4) The failure to provide services in a timely manner, as defined in this Contract. (5) The failure of the Contractor to act within the timeframes provided in 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (6) For a resident of a Rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under 438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.
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.
Appeal	Review by the Contractor of an Adverse Benefit Determination.
Beneficiary	A Child determined eligible for the Medicaid program dental benefit.
Billing Issue	Any situation in which a beneficiary has received a bill for services that they believeshould have been covered by Medicaid.
Blanket Purchase Order (BPO)	Alternative term for “Contract” used in the State’s computer system Michigan Automated Information Network (MAIN).
Business Day	Monday through Friday, 8:00 AM through 5:00 PM EST (unless otherwise stated) not including State or federal holidays.
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
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 CapitatedRate)	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	Care coordination could include any activity that helps to ensure that the beneficiary's dental needs are met over time, such as: provide support of beneficiary’s connection to dental-related services and resources, assistance with finding a dental home/dental provider (which could include appointment making assistance and coordination of transportation needs); referrals to address social determinants of health or social resources that may impact a beneficiary, referral tracking; and information sharing with the state.
Caries Risk Assessment (CRA)	A tool developed by the American Dental Association to assess an individual's oral risk factors, protective factors and clinical findings related to dental caries adopted by MDHHS for HKD Beneficiaries.
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.

TERM	DEFINITION
Child	An individual under the Age of 21.
Children with Special Needs	HKD beneficiaries with special health care needs including but not limited to children with physical, mental and/or behavioral health disabilities or impairment, autistic children, children in Foster Care and CSHCS programs.
Children's Special Health Care Services (CSHCS)	A program for individuals with a qualifying health condition(s) eligible to receive services under Title V of the Federal Social Security Act.
Children's Health Insurance Program (CHIP)	The CHIP was created by the Balanced Budget Act of 1997 and enacted Title XXI of the Social Security Act. CHIP is a joint state-federal partnership that provides health insurance to low-income children.
Clean Claim	All claims as defined in 42 CFR §447.45 and MCL 400.111i.
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	A plan for developing policies and defining actions to improve Population Health.
Community Health Workers (CHWs)	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.
Complaint	A communication by a Beneficiary or a Beneficiary's representative to the Contractor expressing a concern about care or service provided by the Contractor or dental provider presenting an issue with a request for remedy that can be resolved informally. Complaints may be oral or written.
Contract	A binding agreement entered into by the State of Michigan and the Contractor; see also "Blanket Purchase Order."
Contractor	An entity that enters into agreement with the State of Michigan to provide the scope of services required under this Contract.
Covered Services	All Dental Services provided under Medicaid, as defined in Schedule A, section 1.0, which the Contractor has agreed to provide or arrange to be provided under the terms of this Contract.
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.
Days	Calendar days unless otherwise specified.
Deliverables	Physical goods, services, and/or commodities as required or identified under the Contractor Requirements.
Dental Plan	A Dental vendor contracted with the State to provide or arrange for the delivery of Dental Services to Medicaid Enrollees that utilizes a managed care model, in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of Dental Services. A Dental Plan must have a Certificate of Authority from the State to provide oral health care services to Enrollees.
Dental Services	Care and procedures rendered by, or under the supervision of, Dentists for diagnosis or treatment of dental disease, injury, or abnormality, based on valid dental need according to accepted standards of dental practice.

TERM	DEFINITION
Dentist	A person licensed to practice dentistry in Michigan.
Department of Insurance and Financial Services (DIFS)	Responsible for oversight of insurers, Health Maintenance Organizations (HMOs), and financial entities doing business in the State.
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 Dental Health Plan.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Federal mandate that provides comprehensive, preventive, and Medically Necessaryhealth care services for children under age 21 who are enrolled in Medicaid.
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.
Emergency Dental Services	Care for an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or avulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.
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	Dental records containing detail for each enrollee encounter with a Provider for Dental Services for which Contractor paid Providers for Covered Services.
Enrollee	Any HKD Beneficiary who is currently enrolled in the Contractor's managed care Dental Plan.
Enrollment Services Contractor	An entity contracted with MDHHS to contact and educate HKD beneficiaries about managed care and to assist beneficiaries to enroll, dis-enroll, and change enrollment with their Contractor.
Excluded Services	Excluded services are services that are not included in the Contractor's monthly capitation rate.
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 for cases which a provider indicates, or the Contractor determines, that following the standard timeframes could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor must make an Expedited Authorization Decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours after receipt of the request for service. The Contractor may extend the 72-hour period by up to 14 calendar days if the Enrollee requests an extension, or if the Contractor justifies (to MDHHS) a need for additional information and how the extension is in the Enrollee's interest.
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.

TERM	DEFINITION
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)	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)	Agency that provides EQR data analysis and assessment services.
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.
Fiscal Agent	An entity that manages fiscal matters on behalf of another party.
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 information held by governments or governmental entities.
Grievance	Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (42 CFR 438.400). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.
Health Equity	When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
Health Insurance	A contract that requires a health insurer to pay some or all of an enrollee's health care costs in exchange for a premium.
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.
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 Kids Dental (HKD)	Dental program administered by Contractor on behalf of the Department for Medicaid beneficiaries under the age of 21.
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).
Initial Appointment	The first scheduled oral examination by a General Dentistry provider for a new patient admitted into the practice.
Initial Enrollment	First enrollment in Dental Plan following determination of eligibility; re-enrollment in a Dental Plan following a gap in eligibility of less than two month is not considered initial enrollment.

TERM	DEFINITION
Licensing and Regulatory Affairs (LARA)	The State agency that is responsible for the State's regulatory environment and oversees licensing and regulation.
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	MDHHS must approve materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.
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 organization that provides or arranges for the delivery of comprehensive health care services to Medicaid Enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as an HMO.
Medical Necessity or Medically Necessary	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.
Michigan Compiled Laws (MCL)	The official codification of statutes for the State of Michigan.
National Association of Insurance Commissioners (NAIC)	The U.S standard-setting and regulatory support organization whose main responsibility is to protect the interests of insurance consumers.
National Committee for Quality Assurance (NCQA)	A private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.
National Provider Identifier (NPI)	A unique 10-digit identification number issued to health care providers in the United States by CMS.
Network Capacity	The number of Enrollees or Potential Enrollees that the Contractor can serve through its Provider Network under a Contract with the State. Network Capacity is determined by MDHHS in consultation with the Contractor based upon its Provider Network organizational capacity, available risk-based capital, and the Contractor's ability to meet the Network adequacy and access to care standards and requirements in this Contract.
Non-Participating Provider	A provider that has not entered into a contract with an insurance plan.
Oral Health Disparities	A particular type of oral health difference that is closely linked with social or economic disadvantage.
Oral Risk Assessment (ORA)	A tool developed by the American Dental Association to assess an individual's oral risk factors, protective factors and clinical findings related to dental caries adopted by MDHHS for HKD Beneficiaries.
Out-of-Network	Covered Services rendered to a Beneficiary by a provider who is not part of the Contractor's Provider network.
Pediatric Specialist	A dental Pediatric Specialist is an age-defined specialist that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs licensed and certified by LARA.
Per Member Per Month (PMPM)	Capitated unit price payments to contracted primary care.

TERM	DEFINITION
Periodicity Schedule	Guidelines for dental visits by age; the Department follows the American Academy of Pediatric Dentistry (AAPD) guidelines.
Physician Incentive Plan (PIP)	Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.
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.
Potential Enrollee	HKD Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an Enrollee of a specific Contractor or other Managed Care Organization.
Preauthorization	The requirement that a provider allow the Contractor to review proposed care ahead of time and determine that the service is medically necessary and a covered service under the plan.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
Preventive Services	Preventive Dental Services include services such as oral evaluations, routine cleanings, x-rays, sealants, and fluoride treatments.
Provider (or Network Provider)	An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any Subcontractor, for the delivery of Covered Services to Enrollee .
Provider Contract	An 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, 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 Improvement Committee (QIC)	Committee of qualified professionals whose purpose is to continually measure quality and share those measures and results with each other to better able initiate process change and use "Evidence-based" practices to provide the best quality of care to patients served.
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: Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft Region 2: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford Region 3: Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon Region 4: Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa Region 5: Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw Region 6: Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola Region 7: Clinton, Eaton, Ingham Region 8: Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Region 9: Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw Region 10: 10. Macomb, Oakland, Wayne

Routine Care	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.
Rural	Rural is defined as any county not designated as metropolitan or outlying metropolitan by the Office of Management and Budget.

TERM	DEFINITION
Rural Health Clinic (RHC)	Public, non-profit, or for-profit healthcare facility located in rural medically underserved areas. In Michigan, RHCs are certified by the Department of Licensing and Regulatory Affairs (LARA) to participate in Medicare and Medicaid programs under an agreement with CMS. The current RHCs in Michigan are listed as the following website: Federal - Rural Health Clinics (michigan.gov).
Social Determinants of Oral Health	The complex, integrated, and overlapping social structures and economic systems that are responsible for most oral health inequities. These social structures and economic systems include the social environment, physical environment, oral health and physical health services, and structural and societal factors. Social determinants of Oral health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.
Service Authorization Decision	Contractor's written response to Enrollee's Service Authorization Request provided as expeditiously as the Enrollee's condition requires and with State-established timeframes that may not exceed 14 calendar days following the receipt of the request for service, with a possible extension of up to 14 additional calendar days if: (i) The Enrollee, or the provider requests an extension; or (ii) The Contractor justifies a need for additional information and how the extension is in the Enrollee's best interest.
Service Authorization Request	A managed care Enrollee's request for the provision of a service.
State	The State of Michigan, including any departments, divisions, agencies, offices, commissions, officers, employees, and agents.
State Fair Hearing	An impartial review by the State requested by a Medicaid Beneficiary of an adverse determination made by the Contractor held before an Administrative Law Judge through MDHHS' administrative hearing process.
Subcontract	A written contract between the Contractor and a third party to perform any of the Contractor's administrative obligations under this Contract, excluding contracts with Network Providers.
Subcontractor	Any person or entity that performs required, ongoing administrative or Benefit management functions for the Contractor.
Third Party Liability (TPL)	Other dental insurance plan or carrier.
United States Code (USC)	A consolidation and codification by subject matter of the general and permanent laws of the United States.
Urgent Care	Services required to prevent serious deterioration of oral health following the onset of an unforeseen condition or injury.
Utilization Management (UM)	Oral health decisions relating to an individual’s care.
Waste	The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.

APPENDIX T Transition of Care

PURPOSE:

This appendix outlines requirements for continued services to enrollees provided under transition of care policy by a Medicaid Health Plan (MHP) and/or Dental Health Plans (DHP) that are participating in ManagedCare. The transition of care policy applies to enrollees whose health would be jeopardized if health care services ceased or were disrupted during their transition from Fee for Service (FFS) to an MHP and/or a DHP entity or transitioning from one MHP or DHP entity to another. Hereinafter, MHP and DHP will be referred to as "Contractor".

When developing and executing the transition of care policy, Contractor should take into consideration the impact on a member's health of losing access to their established providers. Contractor must be thoughtful about prioritizing members whose health may be jeopardized if their health care services were disrupted during their transition from FFS to the Contractor, or from one Contractor to another. In establishment of this policy, MDHHS isrecommending that Contractor's exercise their clinical expertise and commitment to the optimal health outcomes of their beneficiaries when following these requirements.

BACKGROUND:

Transition of care requirements for Medicaid Managed Care are defined under 42 CFR, Section (§) § 438.62and § 457.1216 - Continued services to enrollees including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Michigan Department of Health and Human Services has the following requirements to be met by an MCO or PAHP in accordance with Federal Regulations related to Transition inCare policy (§) § 438.62 and § 457.1216.

The Contractor's transition of care policy at a minimum must follow the following requirements:

The Contractor must have in effect a *transition of care policy* to ensure its member has continued access tonecessary services as specified in the Federal regulations.

1. **Public Availability**

   The Contractor must make their transition of care policy publicly available and provide instructions to members on how to access continued services upon transition. The policy must be described in the member handbook in accordance with § 438.10 and must be described in the quality strategy (as in §438.340). The transition of care policy may be posted on the website to fulfill the public availability requirement, in addition to adding the language in the member handbook.

2. **Applicability of the policy**

   The transition of care policy is applicable to members if, during a transition, in the absence of continuedaccess to necessary services, the member would suffer serious detriment to their health or be at risk ofhospitalization or institutionalization.

   The Contractor shall address continuity of care for all such Enrollees and include specific policies andprocedures for the following individuals to ensure uninterrupted services which disrupt medically necessary services including but not limited to:

Enrollees who, at the time of their Enrollment:

- Have significant health care needs or complex medical conditions.
- Are receiving ongoing services such as dialysis, home health, chemotherapy and /or radiation therapy.

CSHCS Enrollees Only

- If CSHCS Enrollee transition requirements conflict with transition of care policy requirements, CSHCS transition requirements outlined in this contract shall supersede.

3. **Out-of-Network Providers Covered by Transition of Care Policy**
   An enrollee's primary care physician, specialists, clinics, dentists are covered by continuity of care requirements.

4. **Prior Relationship with a Provider**
   The enrollee must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances.

   Specialists: The enrollee must have seen the specialist at least *once* within the six months prior to enrollment into a health plan for a nonemergency visit.

   Primary Care Provider: The enrollee must have seen the primary care provider at least *once* within the six months prior to enrollment into a health plan for a non-emergency visit.

   Other Covered Providers: The enrollee may have received services from other providers within the past six months prior to enrollment into the new health plan. The new health plan should review, assess, and coordinate those services, if it determines that the enrollee will suffer serious detriment or be at risk for hospitalization or institutionalization.

   If the health plan cannot determine if a relationship exists based on the available data, the health plan should ask the provider and enrollee to provide documentation of the visit from the medical record or proof of payment to establish the relationship.

5. **Requesting Continuity of Care Coverage**
   The enrollee, his or her appointed representative, or the enrollee's provider may request continuity of care on behalf of the enrollee. Requests for continuity of care should be made by contacting the Contractor's member services department or the enrollee's Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the Contractor.

6. **Processing Request**
   - The transition team must make a good faith effort to assess the transitioned member's history and current medical, dental, behavioral health, and social needs and concerns as soon as possible. If there is a risk of harm to the enrollee, or rescheduling of the appointment would be required, the Contractor must establish protocols for ongoing monitoring of progress and care plan updates, and the request must be completed within three business days. The Contractor must allow a member transitioning from another Contractor to continue to receive services from network and out of network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued

services until medical necessity is addressed. For the purpose of transition of care, medical necessity is met if the service:

- Meets generally accepted standards of medical practice
- Is clinically appropriate in its type, frequency, extent, duration, and delivery setting
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- Is not provided primarily for the economic benefit or convenience of anyone other than the recipient.
- The enrolling Contractor must honor the disenrolling Contractor's prior authorization if any, for a period of 90 days from enrollment into the new Contractor and the prior authorization document should be submitted by the beneficiary or the provider. The Contractor may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service.

7. The transitioned member is eligible for continued, clinically equivalent services by an equivalent provider if, during the previous 6 months, the transitioned member was treated by that provider for a condition that requires follow-up care or additional treatment, or the services have been prior authorized by the previous Contractor;

8. If the transitioned member's specialty provider is no longer available to the enrollee through the new Contractor network, the Contractor must allow the member to continue receiving services from the out of network provider for a minimum of 90 days. This ensures access to services consistent with the access the transitioned member previously received while the new contractor assists the member in selecting a network provider. These time periods are the minimum required and the Contractor has the option to extend these periods at its discretion.

9. **Coverage period**
   The following are the coverage periods for continuity of care.

   Primary Care Providers, Specialists, and other covered providers

   - The Contractor must maintain current providers and level of services at the time of enrollment for 90 days.

   - For those individuals that meet transition of care criteria, the Contractor must honor existing prior authorizations for not less than 90 days for the following services:

   - Scheduled surgeries, dialysis, chemotherapy and radiation, organ, bone marrow and hematopoietic stem cell transplants.

   - For services such as custom-fabricated and non-custom fabricated medical equipment and transportation and CSHCS population services, the coverage will be based on your coverage provisions outlined in this contract and the Medicaid Provider Manual.

   Prescriptions
   The Contractor must provide a transition supply without prior authorization if:

   - The enrollee is taking a drug that is not covered by the Contractor, or
   - The Contractor's rules do not cover the amount ordered by the prescriber, or
   - The drug requires prior authorization by the Contractor, or
   - The enrollee is taking a drug that is part of a step therapy restriction.

For the purposes of this policy, a maintenance drug is defined as a drug where the member has received a 30-day supply of the drug in the previous 90 days. The transition of care processes for prescribed drugs shall be consistent with the requirements outlined in Medicare Part D transition guidelines.

10. 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 will include licensed clinical nurse(s) in addition to the staff necessary to enhance services for the transitioned members and provide support for continuation of the services.

11. The transition of care policy developed by the Contractor will include a communication plan defining how the Contractor will communicate the transition of care process and options to all members and providers involved in care.

12. The Contractor is required to maintain a record of all authorization requests including standard or expedited authorizations requests and any extension of request granted. Contractor must maintain member identifying information (Medicaid ID), Request type (standard or expedited), date of original request, extension request, service code, Dx code, decision made, date of decision, date the member notice was sent, and if denied, the reason for denial.

Appendix U Capitation Rate Certification

Healthy Kids Dental Plan Rate Certification
The Medicaid per member per month rates effective October 1, 2024 are located in the link below:

Medicaid Health Plans (michigan.gov)