

**CONTRACT
BETWEEN
Michigan Department of Health & Human Services
AND
<Health Plan name>**

THIS CONTRACT is made and entered into by the Michigan Department of Health and Human Services (the "Department"), an administrative agency within the executive department of the State of Michigan, having its principal office at 400 S. Pine St., Lansing, MI 48933, and **<Health Plan Name>** ("MA Health Plan"), a corporation organized under the laws of the State of <State> and having a principal place of business at <local in-state address for Health Plan.>

Article I. BACKGROUND

The MA Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to provide an MA Health Plan ("MA Agreement"). Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the MA Health Plan to enter into a contract with **Michigan** to provide or arrange for benefits to be provided, for which a dually eligible individual is entitled to receive. As a result, the MA Health Plan and the Department wish to enter into this agreement which shall outline each party's obligations to provide or arrange for benefits for Dual Eligible Members and to coordinate other administrative activities.

In consideration of the premises and the mutual promises and undertakings herein contained, the parties agree to the following terms and conditions.

Article II. DEFINITIONS

2.01 Cost Sharing Obligations mean those financial payment obligations incurred by the Department in satisfaction of the Deductibles, Coinsurance, and Co-payments for the Medicare Part A and Part B services with respect to Dual Eligible Members. For purposes of this Contract, Cost Sharing Obligations do not include: (1) Medicare premiums that the Department is required to pay under the State Plan on behalf of Dual Eligible Members, or (2) any other services that are covered solely by the Michigan Medicaid Program ("Medicaid").

2.02 Dual Eligible means any Medicare managed care recipient who is also eligible for Medicaid, and for whom the Department has at least partial responsibility for payment of Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB only, QMB Plus, SLMB only, SLMB Plus, QI, QDWI and FBDE.

2.03 Dual Eligible Member means a Dual Eligible who is eligible to participate in, and is voluntarily enrolled in, in the MA Health Plan's MA-PD Plan.

- 2.04 Encounter** means a Medicare Part C covered service or group of covered services, as defined by the MA Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.
- 2.05 Encounter Data** means, in the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.
- 2.06 Full Benefit Dual Eligible (FBDE aka Medicaid only):** An individual who does not meet the income or resource criteria for QMB or SLMB but is eligible for Medicaid either categorically or through optional coverage groups such as medically needy, or special income levels for institutionalized, or home and community-based waivers. FBDEs are eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and co-payments (except for Medicare Part D).
- 2.07 MA Agreement** means the Medicare Advantage Agreement between the MA Health Plan and CMS to provide Medicare Part C and other health plan services to the MA Health Plan's members.
- 2.08 MA-PD Plan** means the CMS approved Medicare Advantage plan sponsored, issued, or administered by the MA Health Plan as defined at 42 C.F.R. § 423.4 and includes, but is not limited to, institutional and dual-eligible special needs plans as defined in the Medicare Advantage Rules.
- 2.09 Qualified Disabled and Working Individual (QDWI)** means an individual who lost their Medicare Part A benefits due to their return to work, but is eligible to purchase Medicare Part A benefits, has an income of 200% federal Poverty Level ("FPL") or less and resources that do not exceed twice the limit for Social Security Income ("SSI") eligibility, and is not otherwise eligible for Medicaid. (Medicaid pays the Part A premiums only.)
- 2.10 Qualifying Individuals (QI)** means an individual entitled to Medicare Part A, with an income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility and is not otherwise eligible for Medicaid. Medicaid pays Medicare Part B premiums only. (There is an annual cap on the amount of money available, which may limit the number of individuals in the group.)
- 2.11 Qualified Medicare Beneficiary (QMB)** means an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare

Part D) (collectively, these benefits are called “QMB Medicaid Benefits”). Categories of QMBs covered by this Contract are:

- A. QMB
- B. QMB Plus or Full Dual Eligible– QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medical Benefits, plus all benefits under the State Plan for fully eligible Medicaid recipients.

2.12 Specified Low-Income Medicare Beneficiary (SLMB): An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less than 120% FPL, and resources do not twice the SSI limit. Categories of SLMBs covered by this Contract are:

- A. SLMB
- B. SLMB Plus- SLMBs who meet the standards for SLMB eligibility, but who also meet the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

2.13 State Plan means the State of Michigan’s plan for the Medical Assistance Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

2.14 Subcontract means an contract between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan’s members.

2.15 Subcontractor means a third party with which the MA Health Plan has a subcontract.

Article III. MA-PD’s HEALTH PLAN’S OBLIGATIONS

3.01 Service Area.

- A. For 2025, the MA Health Plan will offer the MA-PD Plan in the counties or zip codes identified on Appendix D.

3.02 Enrollment

- A. The MA Health Plan will offer the MA-PD Plans identified on Appendix A to Dual Eligibles who:
 - 1. Reside in a **Michigan** county or zip code where the MA Health Plan offers the MA-PD Plan, and
 - 2. Are otherwise eligible to receive the MA-PD Plan.

3. Contractor will indicate on Appendix A what categories of dual eligible beneficiaries it will enroll in each plan.
- B. Unless a Dual Eligible is otherwise excluded under federal Medicare Advantage plan rules, the MA Health Plan will accept all Dual Eligible individuals who select the MA Health Plan's MA-PD Plan without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.
- C. The MA Health Plan will verify an individual's Medicaid eligibility prior to enrollment of that potential Dual Eligible Member. The MA Health Plan may also conduct ongoing eligibility verification of Dual Eligible Members.
- D. As outlined in Section 4.01, the Department will provide MA Health Plan with real-time access to the state's eligibility system or otherwise agree to a data exchange of information that allows the MA Health Plan to verify a potential Dual Eligible Member or Dual Eligible Member's current Medicaid status.
- E. The MA Health Plan may choose to use a Subcontractor to conduct eligibility verification required by this Section so long as the Subcontractor has met the Department's requirements for access to their state eligibility database.

3.03 Benefits.

- A. The MA Health Plan will provide the MA-PD Plan to all Dual Eligible Members who are qualified to receive such services under the eligibility requirements of the MA-PD Plan.
 - a. The MA-PD Plan will provide a copy of its approved Model of Care to MDHHS.
- B. The MA-PD Plan is not required to provide any Medicaid benefits under this Contract. This provision does not limit or otherwise restrict the MA Health Plan's obligation to arrange for or provide care coordination as outlined in Section 3.04, below. The MA Health Plan will maintain current knowledge and familiarity with State benefits through ongoing reviews of Michigan laws, rules, policies, and further guidance as posted on the Department's website.
- C. The MA Health Plan will identify for Dual Eligible Members in the MA Health Plan's Summary of Benefits those benefits the member may be eligible for under the State Plan that are not covered services under the Member's MA Health Plan and coordinate access to such benefits as outlined in Section 3.04. To facilitate this process, the Department will provide the MA Health Plan with the State Plan benefits as outlined in Section 4.02.

3.04 Coordination

- A. The MA Health Plan is responsible for coordinating the delivery of all benefits covered by both Medicare and the State Plan, including when Medicaid benefits are delivered via fee-for-service Medicaid or a Medicaid Managed Care Organization. The MA Health Plan is responsible for coordinating the enrollee's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management. Consistent with the MA Health Plan's Model of Care, coordination of care for Dual Eligible Members by the MA Health Plan will include the following:
1. Identifying for Dual Eligible Members of the Special Needs Plan in the MA Health Plan's Summary of Benefit those benefits the member may be eligible for under the State Plan that are not covered services under the Member's Dual Special Needs Plan to the extent that the Department has provided State Plan benefit information outlined in Section 4.02 of this Contract.
 2. Providing Dual Eligible Members with information (including contact information) to access Medicaid benefits upon the Dual Eligible Member's request or as identified by the case coordinator or other MA Health Plan staff.
 3. Coordinate access to Medicaid covered services upon the Dual Eligible Member's request or as identified by the MA Health Plan's care coordinator. Such coordination may include identification and referrals to needed services, assistance with Medicaid appeals and grievances, assistance in care planning, and assistance in obtaining appointments for needed services.
 4. Identifying Medicaid participating providers for the Dual Eligible Members to the extent the Department has provided such information as outlined in Section 4.02 of this Contract. Once the Department provides an electronic data file list of participating Medicaid providers, the MA Health Plan will identify those health care providers that are participating in both the State Plan and the MA Health Plan's network in the Dual Special Needs Plan's provider directory.
 5. Making information available to MA Health Plan's network providers regarding Medicaid so that they may assist Dual Eligible Members to receive needed services not covered by Medicare.
 6. Providing information to MA Health Plan's network providers about coordination of Medicaid and Medicare benefits for Dual Eligible Members.

- B. The Department will provide contact and resource information, to the extent available, for the State Plan to the MA Health Plan that allows the MA Health Plan to access information regarding the State Plan, including the State Plan's Medicaid benefits, Medicaid providers, State Plan's case managers, and the State Plan's waiver program.
- C. The D-SNP Plan shall establish and maintain a connection with the Michigan Health Information Network ("MiHIN") and participate in the ADT Use Case to receive daily or near real time notifications regarding hospital inpatient admissions and skilled nursing facility ("SNF") admissions to the MA Health Plan's contracted hospitals and SNFs for the purpose of coordinating care with full benefit Dual Eligible Members' (QMB Plus) Medicaid Managed Care Entity(ies) and/or State Medicaid Agency, and SNF or hospital staff as deemed necessary to ensure care transition planning.
 - 1. MiHIN shall provide the Department an audit report annually that summarizes the ADT notifications delivered to each MA Health Plan.

3.05 Enrollee Liability for Payment.

- A. Neither the MA Health Plan nor any of its Subcontractors may collect any additional payment for Cost Sharing Obligations from a Dual Eligible Member other than what is allowed by federal law.
- B. The MA Health Plan must notify its Subcontractors (via a provider manual, provider bulletin, or other contractual document) that they may not seek additional payments for Cost Sharing Obligations from Dual Eligible Members for health care services rendered to Dual Eligible Members. The MA Health Plan must notify its Subcontractors that they must seek payment from the Department for such Cost Sharing Obligations. The MA Health Plan must provide the Department contact identified in Section 7.08 with a copy of such written notice.

3.06 Coordination of Benefit Payments

- A. The Department is responsible for adjudicating the Cost Share Obligations under the State Plan.
- B. The MA-PD claims system will adjudicate claims in accordance with Medicare benefits and provide Evidence of Payment information to providers which identifies coordination amounts for their claim submission to the State Medicaid Program for adjudication.

Article IV. DEPARTMENT OBLIGATIONS

Section 4.01 Eligibility Verification

The Department agrees to provide the MA Health Plan or its Subcontractor with real-time access to information that permits the MA Health Plan to verify eligibility of enrolled and potential Dual Eligible Members. The Department will assist the MA Health Plan with information to allow the MA Health Plan to identify the specific categories of eligibility of Dual Eligibles. Information obtained by the MA Health Plan from the Department's eligibility verification system shall not be used by the MA Health Plan for marketing purposes.

Section 4.02 Sharing of information

The MA Health Plan has to obtain certain pieces of information from the Department to comply with CMS requirements for MA-PD Plans that meet CMS requirements for Dual Special Needs Plans. In particular (i) the Department will make available to the MA Health Plan a list of participating Medicaid providers on at least an annual basis, and (ii) the Department will make available to the MA Health Plan a list of health care services and products covered under the State Medicaid Program on an annual basis or by May of the preceding year if CMS requires the MA-PD Plan to provide such information in the MA-PD Plan's Summary of Benefits. The benefits under the State Plan are identified in Appendix B.

Article V. TERM, TERMINATION

Section 5.01 Term.

The initial term of this Contract will begin on January 1, 2025 (the "Effective Date") and end on December 31, 2025. Upon expiration of the initial term, the term of this Contract shall automatically renew for one successive twelve (12) month renewal term beginning January 1, 2026, and ending on December 31, 2026, unless either Party provides the other with written notice of nonrenewal no later than October 1st of 2025.

Section 5.02 Termination.

A. This Contract may be terminated by mutual agreement of the parties. Such agreement must be in writing.

B. The Department reserves the right to terminate this Contract immediately upon notification to the MA Health Plan. The Department will provide the MA Health Plan written notice of such termination at least sixty (60) calendar days prior to the effective date of termination, unless the Department reasonably determines that circumstances warrant a shorter notice period.

- C. The MA Health Plan may terminate this Contract by providing the Department written notice at least sixty (60) calendar days prior to termination. The termination will be effective on the date specified in the MA Health Plan's notice of termination.
- D. In the event of termination pursuant to this Section, the Department will continue to provide the MA Health Plan access to the state's eligibility database for purposes of confirming Medicaid eligibility for six (6) months to allow the MA Health Plan to continue to confirm eligibility of Dual Eligible Members. In addition, the parties shall discuss whether to enter into an alternative arrangement for the exchange of Medicaid eligibility information.

Article VI. Dispute Resolution

Section 6.01 General Agreement of the Parties.

The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this Contract. The parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

Section 6.02 Duty to Negotiate in Good Faith.

- A. Any dispute that in the judgment of any party to this Contract may materially or substantially affect the performance of this Contract will be reduced to writing and delivered to the other party. The parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by agreement between the parties shall be reduced to writing and delivered to all parties within ten (10) business days.
- B. In the event the dispute cannot be resolved by negotiated agreement as noted above, the parties may agree to a neutral third-party alternate dispute resolution including mediation and/or arbitration.

Article VII. MISCELLANEOUS PROVISIONS

Section 7.01 Entire Agreement

This Contract contains the entire understanding between the parties hereto with respect to the subject matter of this Contract and supersedes any prior understandings,

agreements or representations, written or oral, relating to the subject matter of this Contract.

Section 7.02 Signatures & Counterparts

This Contract will be effective only when signed by both parties. This Contract may be executed in separate counterparts, each of which will be an original and all of which taken together will constitute one and the same contract, and a party hereto may execute this Contract by signing any such counterpart.

Section 7.03 Non-Debarment

The MA Health Plan represents that neither it nor any of its principles is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program.

Section 7.04 Severability.

Whenever possible, each provision of this Contract will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this Contract is held to be invalid, illegal or unenforceable under any applicable law or rule, the validity, legality and enforceability of the other provisions of this Contract will not be affected or impaired thereby.

Section 7.05 Successors & Assigns

This Contract will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by Section 9.06, successors and assigns.

Section 7.06 Assignment.

This Contract and the rights and obligations of the parties under this Contract will be assignable, in whole or in part, by the MA Health Plan with the prior written consent of the Department's point of contact identified in Section 7.08.

Section 7.07 Modification, Amendment, or Waiver.

No provision of this Contract may be modified, amended, or waived except by a written signed by parties to this Contract. No course of dealing between the parties will modify, amend, or waive any provision of this Contract or any rights or obligations of any party under or by reason of this Contract.

Section 7.08 Notices.

All notices, consents, requests, instructions, approvals or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

The Department:

MA Health Plan:

Michigan Department of Health
& Human Services
400 S. Pine St.
Lansing, MI 48933

<Address>

A party may change the contact information set forth above by giving written notice to the other party.

Section 7.09 Headings.

The headings and any table of contents contained in this Contract are for reference purposes only and will not in any way affect the meaning or interpretation of this Contract.

Section 7.10 Governing Law & Venue.

This Contract is governed by the laws of the State of **Michigan** and interpreted in accordance with **Michigan** law, except to the extent preempted by federal law. Provided the parties first comply with the procedures set forth in Article VI, "Dispute Resolution," proper venue for claims arising from this Contract will be in a court of competent jurisdiction in **Michigan**.

Section 7.11 No Third-party Beneficiaries.

Nothing in this Contract, express or implied, is intended to confer upon any other person any rights, remedies, obligations or liabilities of any nature whatsoever.

Section 7.12 Publicity.

Except as otherwise required by this Contract or by law, no party will issue or cause to be issued any press release or make or cause to be made any other public statement as to this Contract or the relationship of the parties, without obtaining the prior approval of the other party to the contents and manner of presentation and publication thereof.

Section 7.13 No Waiver.

No delay on the part of either party in exercising any right under this Contract will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.

Section 7.14 Compliance with Federal and State Law.

The parties agree to comply with all relevant federal and state laws, including but not limited to the following: Bipartisan Budget Act of 2018 and its implementing regulations issued by CMS; Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS; 42 CFR Part 422; Title VI of the Civil Rights Act of 1964, as amended (42 USC§ 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC§§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981 , as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12 101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC§ 6 101 et seq.).

Section 7.15 Acknowledgement of Awareness.

- A. By executing this contract, the MA Health Plan acknowledges it is aware of and understands the following:
 - 1. In May 2022, CMS issued the CY 2023 Medicare Advantage (MA) and Part D Final Rule (CMS-4192-F). Among other things, this rule requires that Michigan phase out its Financial Alignment Initiative (FAI) demonstration programs. The Department has elected to transition to a Highly Integrated Dual Eligible, Special Needs Plan (HIDE-SNP) model that integrates Long Term Services and Supports (LTSS). The department is moving ahead with a competitive bid for contractors to serve in that program.
 - 2. The Department values the opportunities for increased integration of care and improved health outcomes that the alignment of Medicaid and Medicare systems provides, and views increased alignment as a primary tool to achieve its program goals. To support these values, the Department is currently developing a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) program. This program will serve a significant number of dually eligible Medicaid Beneficiaries.
 - a. *Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP)* means a dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract that meets the requirements set forth in 42 CFR 422.2.

3. The Department intends for its HIDE-SNP program to be fully operational January 1, 2026, in limited regions of the State. Over time, the program will be extended to the entire State.
4. The Department intends to stop or limit Coordination Only D-SNP enrollment. Therefore:
 - a. Beginning January 1, 2026, Contractor shall stop or limit enrollment into any plan covered by this contract in accordance with MDHHS direction in the following counties:
 1. Any county in the Upper Peninsula.
 2. Barry
 3. Berrien
 4. Branch
 5. Calhoun
 6. Cass
 7. Kalamazoo
 8. St. Joseph
 9. Van Buren
 10. Macomb
 11. Wayne
 - b. Beginning January 1, 2027, Contractor shall stop or limit enrollment into any plan covered by this contract in accordance with MDHHS direction in all Michigan counties not identified in 4a above.
 - c. The Department may impose limitations on expansion of service areas as established as of December 31, 2025, in future contract years.

IN WITNESS WHEREOF, authorized representatives of the parties execute this Contract to be effective as of January 1, 2025:

Michigan Department of Health & Human Services

<Health Plan Name>

By: _____

By:

Printed Name: _____

Printed Name:

Title: _____

Date: _____

Title:

Date:

APPENDIX A

MA-PD PLAN NAME	CONTRACT NUMBER	CATEGORY OF ELIGIBILITY

Appendix B

Services Covered Under the State Contract (Including, but not limited to)

- a. Ambulance and other emergency medical transportation
- b. Breast pumps; personal use, double-electric
- c. Outpatient mental health services consistent with Appendix 7,
- d. Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- e. Certified nurse midwife services
- f. Certified pediatric and family nurse practitioner services
- g. Chiropractic services
- h. Diagnostic laboratory, x-ray and other imaging services
- i. Durable medical equipment (DME) and supplies including those that may be supplied by a pharmacy
- j. Emergency services
- k. End Stage Renal Disease (ESRD) services
- l. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- m. Health education
- n. Hearing and speech services
- o. Hearing aids
- p. Home Health services
- q. Hospice services (if requested by the Enrollee)
- r. Immunizations
- s. Inpatient and outpatient hospital services
- t. Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 Days
- u. Maternal and Infant Health Program (MIHP) services
- v. Medically Necessary weight reduction services
- w. Non-emergent medical transportation (NEMT) to medically-necessary, Covered Services
- x. Out-of-state services authorized by the Contractor
- y. Parenting and birthing classes
- z. Pharmacy services
- aa. Podiatry services
- bb. Practitioners' services
- cc. Preventive services required by the Patient Protection and Affordable Care Act as outline by MDHHS
- dd. Prosthetics and orthotics
- ee. Restorative or rehabilitative services in a place of service other than a nursing facility
- ff. Sexually transmitted infections (STI) treatment
- gg. Tobacco cessation treatment including pharmaceutical and behavioral support

hh. Therapies (speech, language, physical, occupational and therapies to support activities of daily living) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts

ii. Transplant services

jj. Vision services

kk. Well-child/EPSTD for persons under age 21

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

mm. Dental services for all MA Health Plan beneficiaries

nn. Doula services.

oo. COVID 19 home test kits.

Appendix C

Additional Information for People with Medicare and Medicaid:

*Services and coverage subject to periodic changes as required by Michigan Medicaid Program

Benefit Category (Excludes Medicare-covered services)	Medicaid Covered Services (FFS)
Dental Services	<p>For beneficiaries who are 21 years and older, the following services are covered:</p> <ul style="list-style-type: none"> • X-rays • Teeth cleanings • Fillings • Extractions • Dentures • Deep teeth cleanings (New) • Sealants (New) • Root canals (New) • Crowns (New) • Care to keep your gums healthy (New)
Medical/Surgical Services of Dentist	As above
Hearing Aids	Hearing aid delivery, repair and modifications, replacement ear-molds, supplies and accessories batteries as of 9/1/2018.
Optometrist Services	One eye exam every two years
Podiatrist Services	Routine No Covered <21. Over 21, no podiatry services are covered.
Dentures	Not covered
Eyeglasses	2 replacements per year < 21. Two contact lens replacement in a year for each eye for <21.
Non-Emergency Transportation	Medical transportation through DHS with no limits. Medicaid Health Plans cover NEMT for transportation to obtain medical services.
Targeted Care Management	Not covered, except for those members pregnant women and children up to age 21 who were served by the Flint Water system from April 1, 2014 to present.
Personal Care Services	Covered through LTC waiver program
Inpatient/SNF/ICF for Mental Diseases	Covered through PIHP and waiver services

Inpatient Psychiatric Services	Covered in full for qualified individuals through PIHP providers
Intermediate Care Facilities for the Mentally retarded (ICFIMR)	<p>Covered in full Medicaid bed facility for qualified individuals.</p> <p>3.13 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH MENTAL RETARDATION (ICFIMR) SERVICES</p> <p>Health and rehabilitative services provided in a state-licensed facility of 16 beds or less that is certified to meet ICFIMR STANDARDS THAT ARE SPECIFIED IN 42 CFR 483.400 AND 42 CFR 442 Subpart C. Beneficiaries must meet ICFIMR level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified mental retardation professional (QMRP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self determination and independence as possible, and the prevention of deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1) (i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications.</p>
Pharmacy	Benzodiazepines, Barbiturates, select OTCs, select vitamins and agents used to promote smoking cessation.

Appendix D

Service Area

MA-PD PLAN NAME	CONTRACT NUMBER	SERVICE AREA