SCHEDULE A – STATEMENT OF WORK

Contract No. _____

Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs)

Department of Health and Human Services

STATEMENT OF WORK CONTRACT ACTIVITIES

Ver 2.0

This schedule identifies the requirements of this Contract

Background

In May 2022, CMS finalized a requirement for states participating in the Financial Alignment Initiative capitated model demonstration to end their programs by 12/31/2025 or transition them into integrated Dual Eligible Special Needs Plans (D-SNP).

Michigan submitted a letter of intent to CMS to transition MI Health Link (MHL) to an integrated DSNP by January 1, 2026.

To align with the new CMS rules, MDHHS will transition the MHL Program to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP).

- A HIDE-SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of those dually eligible for Medicare and Medicaid.
- The HIDE-SNP will integrate long-term service and supports (LTSS) and contracted managed care plans will provide all Medicare and most Medicaid covered benefits for their dual-eligible enrollees through capitated, D-SNP only contracts, but specialty Medicaid behavioral health services will remain carved out and will continue to be provided by Regional Pre-Paid Inpatient Health Plans (PIHPs).

MDHHS remains committed to ensuring the improved care experience for low-income seniors and people with disabilities who are Medicare-Medicaid enrollees through a HIDE-SNP; with the expectation of providing the greatest degree of continuity in the program benefits and expectations for beneficiaries, providers, and health plans.

The Integrated Care Transition Pillars include:

1. Foster Integration and Continuity – The goal of the HIDE-SNP program is to continue to improve quality and access to care by

aligning Medicare and Medicaid and bridging the divide between the physical health, long term care, and behavioral health systems. Enrollee's providers and amount, scope and duration of services at the time of enrollment must be continued until the enrollee can be assessed.

2. Reduce Racial Disparities – MDHHS will use a data driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source. MDHHS will work to reduce causes of inequitable access to programs and services that impact social determinants of health. Input will be gathered from stakeholders at all levels to ensure services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The HIDE-SNP program will incorporate processes to align program operations and strategies related to quality of care and services, data driven outcomes measurement, and address social determinants of health, health equity and disparities. MDHHS will improve service delivery to ensure that all eligible individuals receiving services have equitable access to services and resources to improve health outcomes and reduce racial disparities.

3. Improve Care Delivery – Care delivery in the HIDE-SNP program will be based on a person-centered approach that emphasizes the whole person and care coordination to comprehensively address enrollees' needs.

4. Promote Self Determination – MDHHS values and will require pathways that provide enrollees with meaningful authority to control and direct long-term supports and services in the HIDE-SNP program. True self-determination requires a shift from the approaches that fit enrollees into an existing service array to approaches that are truly enrollee-centered and enrollee-controlled. Arrangements that support self-determination ensure methods for enrollees to exert direct control over how, by whom, and to what ends they are served and supported.

5. Build a Culture of Quality - The HIDE-SNP program will incorporate principles of continuous quality improvement into all aspects of its operations. Using an integrated data driven approach to monitoring, prioritizing, and identifying quality improvement opportunities, it will aim to improve outcomes and ensure timely access to high-quality services for dually eligible Enrollees. Through policy development and targeted interventions, it will advance MDHHS' strategic quality

objectives of providing high quality care and high levels of access to care, strengthening person and family-centered approaches to care, promoting effective care coordination and communication of care among managed care programs, providers, and stakeholders, reducing racial and ethnic disparities in healthcare and health outcomes, and improving quality outcomes and disparity reduction through value-based initiatives and payment reform.

SCOPE

MDHHS seeks to increase integration of care and improve health outcomes through increased alignment of Medicaid and Medicare. The purpose of this Contract is to establish a program offering direct contracts with Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs). HIDE SNPs will provide aligned coverage of most Medicaid benefits, excluding certain behavioral health services, but including long-term services and supports, under a capitated contract that meets the requirements set forth in 42 CFR 422.107. The HIDE SNP program will be fully operational commencing January 1, 2026, in limited regions of the State of Michigan ("State").

1. Applicable Laws, Regulations, and Interpretations list.

    a. Contractor has entered into a contract with the Centers for Medicare & Medicaid Services ("CMS") to provide a HIDE SNP ("MA Agreement").

    b. Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires Contractor to also enter into an agreement with the State to provide or arrange for benefits to be provided, for which a dually eligible individual is entitled to receive.

2. Under the Bipartisan Budget Act of 2018 and resulting regulations, CMS requires Contractor to maintain a level of integration as determined by the State. MI is pursuing D-SNP only contracts pursuant through 42 CFR 422.107(e), and as such, requires MA organizations offering HIDE SNPs in Michigan to do the following

    a. Apply for, and seek CMS approval to establish and maintain, a contract that only includes one or more dual eligible special needs plans with a service area limited to the State.

b. Use required materials that integrate Medicare and Medicaid content, including at a minimum the Summary of Benefits, Formulary, and combined Provider and Pharmacy Directory that meets Medicare and Medicaid managed care requirements consistent with applicable regulations in parts 422, 423, and 438 of 42 CFR Subchapter B.

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

On January 1, 2026, the Contract will be implemented in Region 1, Region 8, Region 10, and Region 12. (For definitions of regions and counties included in each region see Section 3 below and Appendix B.)

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1. General

1.1 General Requirements.

A. 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.

B. Contractor must comply with all provisions of The Medicaid Providers Manual (found at

https://www.mdch.state.mi.us/dchmedicaid/manuals/MedicaidProviderManual.pdf)

and Medicaid Policy as it may be amended from time to time (found at Policies & Practice Guidelines) applicable to Contractors unless provisions of this Contract stipulate otherwise.

C. All policies, procedures, operational plans, and clinical guidelines followed by Contractor must be in writing and available to MDHHS upon request.

D. All medical records, report formats, information systems, liability policies, Provider Network information, and other details specific to performing the contracted services must be available to MDHHS upon request, or as otherwise required to be delivered pursuant to the terms of this Contract.

E. Capitalized terms not otherwise defined herein are defined in Appendix A.

F. Contractor and MDHHS wish to enter into this Contract that will outline each party's obligations to provide or arrange for Covered Services and any other benefits set forth herein, for Enrollees 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.

G. Contractor must comply with all applicable provisions of federal and State laws, policies, regulations, guidance, waivers and standards, and Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423.

1.2 Service Area.

A. Contractor will offer the HIDE SNP to Enrollees who: (1) reside in a Michigan Region where Contractor is approved by CMS and MDHHS to offer the HIDE SNP, and (2) are otherwise eligible to enroll in the HIDE SNP. Michigan Regions are defined in Section II.C.3.

B. A table has been included in Appendix B that incorporates each Medicare Advantage contract number and plan ID covered by the Contract, along with the counties served by each plan.

C. Michigan Regions.

   a. Contractor must operate in one or more of 12 Regions throughout the State for the provision of Covered Services.

   b. Contractor must provide services in accordance with this Contract to beneficiaries residing in all Counties within the Region(s) it is approved to cover.

   c. Contractor must provide evidence of Medicaid network adequacy to MDHHS annually and as required in this Contract. Regions are defined and numbered as follows:

      i. Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

      ii. Region 2: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford

      iii. Region 3: Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon

      iv. Region 4: Allegan, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa

      v. Region 5: Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw

      vi. Region 6: Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola

      vii. Region 7: Clinton, Eaton, Ingham

      viii. Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren

ix. Region 9: Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw

x. Region 10: Macomb

xi. Region 11: Oakland

xii. Region 12: Wayne

d. Contractor must only enroll eligible beneficiaries residing within the counties in its service area.

D. Service Area Expansion. Expansion of, or changes to, Contractor's Service Area will be at the sole discretion of MDHHS with approval from CMS.

E. Contiguous County Service Area

a. Contractor must provide services in their Contracted Service Area through the use of Medicaid Network Providers in contiguous counties outside their Contracted Service Area, subject to MDHHS approval.

b. Contractor must provide a complete description of the Medicaid Provider Network, including the identification of the contiguous counties with an available Medicaid Network Provider and the counties in the Region to be served through this Medicaid Network Provider.

2. Eligibility and Enrollment

2.1 HIDE SNP Eligible Populations

A. The HIDE SNP will be available to individuals who meet all of the following criteria:

a. Age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program

b. Entitled to Medicare Part A, Medicare Part B, and Medicare Part D

c. Receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount)

d. Reside in a covered Service Area as defined in this contract in Appendix B.

2.2 HIDE SNP Excluded Population

A. The following individuals will be excluded from initial and ongoing enrollment with Contractor unless otherwise indicated:

a. Individuals under the age of 21

b. Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 C.F.R. § 438.56

c. Individuals not living in a HIDE SNP Service Area

d. Individuals who are eligible for partial Medicaid coverage through the following eligibility groups: Additional Low Income Medicare Beneficiary (ALMB), Qualified Individual (QI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Disabled and Working Individuals (QDWI)

e. Individuals without full Medicaid coverage (including those with spend downs or deductibles)

f. Individuals with Medicaid who reside in a State psychiatric hospital

g. Individuals with other comprehensive health coverage including commercial HMO coverage

h. Individuals who elected hospice services prior to HIDE SNP enrollment

i. If an existing HIDE SNP Enrollee elects to receive hospice services, the Enrollee may remain enrolled in the HIDE SNP and will only be disenrolled at the Enrollee's request.

i. Individuals who are incarcerated

j. Individuals with presumptive eligibility

k. Individuals not eligible for Medicaid due to divestment

l. Individuals residing in designated State sanctioned Veterans' Homes.

2.3 Eligibility Determination and Verification

A. CMS and MDHHS will have sole responsibility for determining eligibility for Medicare and Medicaid, respectively.

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

C. Contractor will verify an individual's Medicare and Medicaid eligibility prior to enrollment of that potential Enrollee with Contractor.

D. Contractor must verify Medicaid eligibility using resources and systems provided by MDHHS including the 270/271 process. Once a potential Enrollee is enrolled with Contractor, Contractor must also monitor 834 files and CHAMPS on an ongoing basis for eligibility, enrollment, demographic, and other administrative changes.

E. If the necessary documentation to complete the enrollment request is not received within 21 calendar days of the request, the plan must deny the enrollment in accordance with CMS procedures outlined in Medicare Advantage and Part D Enrollment and Disenrollment Guidance § 50.4.

2.4 Contractor Enrollment

A. Enrollment into a Michigan HIDE SNP is voluntary

B. Contractor must accept new enrollments, make enrollments effective, and limit involuntary disenrollments, as provided in subpart B of 42 CFR 422 and the policies and procedures set forth in this Contract.

C. Involuntary disenrollment requests due to disruptive behavior in accordance with 42 CFR §§ 422.74(d)(2), 422.74(e)(1) must be submitted to the Contractor's Medicare Account Manager for review and approval.

a. Involuntary disenrollment requests in accordance with 42 CFR 438.56 are limited to substantiated allegations of Medicaid fraud committed by the enrollee and must be submitted to the Contractor's MDHHS Contract Manager for review and approval.

b. Contractor must accept enrollment for all Potential Enrollees, as described in this section at any time without regard to physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin,

ancestry, pre-existing conditions, expected health status, or need for health care services.

F. Exclusively Aligned Enrollment (EAE) is Required

a. Contractor must limit enrollment to HIDE SNP Eligible Populations as described in Section III. A of this Contract thereby establishing and maintaining Exclusively Aligned Enrollment, as defined in 42 CFR 422.2, in the HIDE SNP.

2.5 Methods of Enrollment

A. Using a Medicare Advantage Agent or Broker

a. If Contractor uses Agents and Brokers or makes payments to third party marketing organizations to sell its HIDE SNP plan, Contractor must adhere to all applicable Michigan laws and regulations related to the licensure and activities of Agents and Brokers and follow all requirements set forth in 42 CFR 422.2274 and 423.2274 as applicable.

b. Contractor must ensure brokers have access to trainings specific to LTSS.

2.6 Deemed Enrollment

A. Contractor must offer Enrollees who lose Medicaid eligibility not less than a three-month deeming period of continued enrollment in the HIDE SNP to minimize risks and maximize continuity of care during periods of temporary Medicaid eligibility loss, in accordance with 42 CFR §422.52(d). During any period of continued enrollment, Contractor will provide all Medicaid services called for under this contract.

B. Contractor or its authorized agent must monitor Medicaid eligibility for deemed Enrollees using daily 834s and the 270/271 process at least monthly.

a. If an Enrollee regains Medicaid eligibility within the deeming period, MDHHS will notify Contractor via a daily 834 enrollment file and will reinstate the Enrollee in the HIDE SNP.

b. Reinstatement in the HIDE SNP will only occur for months during the period of deemed enrollment that the Enrollee has regained full Medicaid.

C. Contractor will receive capitation payments for months the Enrollee's HIDE SNP coverage has been reinstated.

   a. Medicaid Capitation payments for months where an Enrollee's HIDE SNP coverage has been reinstated for a previously deemed enrollment period that do not reflect Medicaid encounters for services rendered during the deemed period are subject to recoupment.

D. Contractor must submit Medicaid encounters for services rendered during months of deemed enrollment once the Enrollee's coverage has been reinstated in the HIDE SNP.

E. Contract may not adjust the period of deemed enrollment it offers more often than annually. Contractor must report its period of deemed enrollment to MDHHS annually.

2.7 Enrollment Files and Transactions

A. Contractor must submit HIDE SNP enrollments and disenrollments to CMS in accordance with State and Federal requirements and the provisions of this Contract. MDHHS will leverage file exchange information from CMS to process Medicaid enrollments and disenrollments in CHAMPS.

B. Upon MDHHS approval of enrollments submitted by Contractor to CMS, MDHHS will generate 834 Audit files to send electronically to Contractor monthly which will serve as MDHHS' official list of HIDE SNP enrollment for Contractor that month.

C. MDHHS will send Contractor daily HIPAA-compliant 834 files for its active members which will include data on enrollment, disenrollment, cancellations, errors, eligibility determinations, deeming, demographics, and other information necessary for service delivery, reconciling discrepancies, and facilitating care coordination.

D. Contractor must update its records with information provided on the daily and monthly 834 files to assure compliance with State, Federal, and contractual obligations.

E. If MDHHS notifies Contractor in writing of enrollment changes, Contractor must rely upon that written notification in the same manner as its 834 files.

F. MDHHS will base Contractor Medicaid capitation payments for Medicaid-covered services on enrollment documented in monthly Audit 834 files.

G. For active HIDE SNP Enrollees who meet criteria for HCBS waiver services and have a documented need in their ICP, Contractor must submit HIDE SNP HCBS waiver enrollments and disenrollments directly in CHAMPS in accordance with MDHHS expectations.

H. For individuals whose Medicaid eligibility is dependent on them receiving HCBS waiver services, Contractor may enroll the person in the HIDE SNP HCBS Waiver at the same time it enrolls the person in the plan. All enrollment rules apply.

I. Contractor must obtain a complete acknowledgment form at the time of enrollment from all individuals receiving services from MI Choice or PACE immediately prior to enrollment with Contractor. The acknowledgment form will be standardized and provided by MDHHS. Contractor must maintain copies of completed forms and make them available to MDHHS upon request. An enrollment application for a prospective member who is enrolled in MI Choice or Pace is not complete until the executed acknowledgment form is obtained. See §III.C.5 above.

    a. If Contractor is unable to reach the applicant or if the applicant requests additional information that requires processing by MDHHS, the plan must notify the applicant (in writing or orally) within 10 calendar days of receipt of the enrollment request that additional information is needed. If contact is made by telephone, the plan must document the contact and retain the documentation in its records. The plan must explain to the applicant that they have 21 calendar days in which to submit the missing information, or the enrollment will be denied.

    b. If the necessary documentation to complete the enrollment request is not received within 21 calendar days of the request, the plan must deny the enrollment in accordance with CMS procedures outlined in Medicare Advantage and Part D Enrollment and Disenrollment Guidance § 50.4.

2.8 Enrollment Verification for Providers

A. Contractor is responsible for keeping its Medicaid network of Providers, Vendors, and Subcontractors that administer Benefits

and Covered Services described in Section IV Covered Services of this Contract informed of the enrollment status of each Enrollee.

B. Contractor must provide a system that supports the electronic verification of Contractor enrollment to Medicaid network providers via the telephone and online portal 24 hours a day and 365 days a year.

C. Contractor must provide initial and ongoing training to its Medicaid network of Providers, Vendors, and Subcontractors on how to use the telephone and online portal to check an Enrollee's enrollment status.

D. The verification systems must provide the name and contact information of the Enrollee's Care Coordinator and PCP.

E. When an Enrollee's enrollment status changes, Contractor must make the updated enrollment status information available to its Medicaid network of Providers, Vendors, and Subcontractors within forty-eight (48) hours of the effective date of the change.

2.9 Enrollment and Disenrollment

A. Disenrollment of an Enrollee's coverage must follow requirements in 42 CFR 422.74.

B. Contractor disenrollment procedures must be in accordance with 42 CFR 422.66, the Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment, and other applicable law and regulation.

C. Contractor must use Daily Transaction Reply Reports (DTRR) to receive timely information about all disenrollments from CMS or its authorized agent, including the effective date of disenrollment.

D. Contractor must use daily and monthly 834 files to receive timely information about all disenrollments from MDHHS, including deeming and disenrollment effective dates.

E. Changes in enrollment will be approved and implemented by MDHHS on a calendar month basis unless Contractor is notified of a mid-month disenrollment on the daily 834 enrollment file.

F. Contractor must submit timely and appropriate disenrollment transactions for Enrollees who have a status change that results in loss of HIDE SNP enrollment eligibility.

G. Requests to disenroll from Contractor or enroll in a different HIDE SNP will be accepted at any point after an Enrollee's initial Enrollment occurs and are effective on the first calendar day of the month following receipt of request.

H. Contractor will notify the Enrollee in writing when the Enrollee no longer meets eligibility requirements for Enrollment in Contractor.

I. During the CMS end of year enrollment process or the plan rollover (Pover) in 2025 and 2026, individuals enrolled in both a CO D-SNP operated by Contractor in Michigan, and Michigan's Program of All-inclusive Care for the Elderly (PACE), Michigan's MI Choice waiver program, a Behavioral Health Home or an Opioid Health Home contracted with the State of Michigan may not be selected for enrollment in Contractor.

3. Covered Services.

3.1 HIDE SNP Requirements

A. For purposes of this Contract, Highly integrated dual eligible special needs plan means a dual eligible special needs plan as defined by 42 CFR §422.2 offered by an MA organization that provides coverage of Medicaid benefits, including primary and acute care, under a capitated contract that meets the following requirements:

a. The capitated Contract is between the State Medicaid agency and the MA organization.

b. This Contract requires the coverage of the following benefits to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a HIDE SNP in the State except as approved by CMS under 42 CFR § 422.107(g) or (h) (See Appendix M).

i. Long-term services and supports, including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year; or

ii. Behavioral health services covered by Medicaid but not provided by Prepaid Insurance Health Plans; and

c. For plan year 2026 and subsequent years, the capitated Contract covers the entire service area for the dual eligible special needs plan.

3.2 Medicare and Medicaid Coverage

A. Contractor must provide an integrated Medicare-Medicaid benefit package to the greatest extent possible.

   a. Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for Enrollees.

   b. Contractor is required to provide at least one mandatory supplemental benefit that complements the LTSS covered under this Contract.

   c. Contractor must report on its LTSS supplemental benefit annually to MDHHS.

   d. When Michigan Medicaid covers services not covered by Medicare or covers a needed service in a greater amount, duration, or scope than Medicare, Contractor must provide these services through Medicaid in accordance with this Contract.

   e. The Enrollee will receive the most expansive set of services offered by either program, with Medicare as the primary payer.

B. Contractor must cover all Michigan Medicaid State Plan and services detailed in HIDE SNP 1915(b)/(c) Wavier applications, except as set forth in this Contract.

C. Supplemental Benefits included in Contractor's Medicare Advantage Contract that overlap with Medicaid State Plan or Waiver benefits must first be adjudicated by Contractor as claims for services under the Medicare Supplemental Benefit before treating such services as Medicaid-covered.

   a. In instances when the Medicaid limit for a service exceeds the Medicare limit for the same service, Contractor must cover the service up to the Medicaid limit.

D. Contractor must provide Enrollees a comprehensive, single Summary of Benefits pursuant to MDHHS guidelines describing all Medicare and Medicaid benefits that Enrollee may be eligible to receive upon enrollment in the plan.

E. When the Contractor receives a request for information from the HIDE-SNP ombudsman program related to a covered service or complaint related to a covered service, the Contractor must

respond timely to that request and any additional follow-up requests.

3.3 Medically Necessary Covered Services.

A. Contractor must have available and provide, at a minimum, the appropriate Medically Necessary Covered Medicaid Services.

B. Contractor's standards for determining Medically Necessary Services must not be more restrictive than standards used by MHDDS, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes, regulations, the State Plan, Medicaid Provider Manual, and other State policies and procedures.

C. Contractor must provide for:

a. The prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

b. The ability for an Enrollee to attain, maintain or regain functional capacity.

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

E. 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.

F. Contractor may place appropriate limits on a service, including:

a. On the basis of criteria applied under the State plan, such as Medical Necessity; or

b. For the purpose of utilization control, provided that

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

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

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

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

H. Contractor has discretion to use the Medicaid Capitation Payment to offer optional benefits, as specified in the Enrollee's Individualized Care Plan, as appropriate to address the Enrollee's needs.

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

   a. Contractor must ensure that there is a written agreement that specifies the activities and report responsibilities delegated to the Subcontractor and provides for revoking delegation (whether by Contractor, MDHHS or CMS) or imposing monetary Sanctions and/or other Sanctions if the Subcontractor's performance is inadequate.

   b. If deficiencies or areas for Improvement are identified, Contractor and the Subcontractor will take corrective action.

J. Contractor must comply with provisions of MCL 400.109(h) as it relates to pharmaceuticals covered under Michigan Medicaid benefit.

K. Unless otherwise specified in this Contract, Contractor must abide by MDHHS' telehealth coverage and reimbursement policies for Medicaid-covered services. (See Final-Bulletin-MMP-23-10-Telemedicine.pdf) https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2023-Bulletins/Final-Bulletin-MMP-23-10-Telemedicine.pdf?rev=b8dc2e9ca6be419c9d4caf3d34440187&hash=34AE818E519E9DC2C712965F75FD076A.

3.4 Medicaid Services Covered Under This Contract

A. Contractor must provide the full range of Covered Services listed in Appendix M and any outreach necessary to facilitate Enrollees use of appropriate services.

B. Contractor may choose to provide services over and above those specified.

3.5 Home and Community-Based Waiver Services

A. Contractor must provide HIDE SNP home and community-based waiver services in accordance with Medicaid State Plan, HIDE SNP 1915c waiver application requirements and as detailed in the HIDE DSNP chapter of the provider manual.

B. Contractor must use an assessment tool identified by the State to determine the amount, scope and duration of the services required for the individual to live in the community and use person-centered planning to determine how the services will be delivered as detailed in the individualized care plan.

C. As set forth in Section 6.11 G, Contractor will ensure that the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) is conducted, as necessary, to determine eligibility for HCBS waiver services.

3.6 State Plan Personal Care Services

A. As set forth in Section 6.11 F, Contractor must ensure that the Personal Care Assessment is conducted, as necessary, to determine eligibility for State Plan Personal Care Services.

B. MDHHS will provide Contractor with the Personal Care Assessment tool specifications to determine time and task for the Enrollee.

3.7 Nursing Facility Care

A. Contractor must provide long term custodial care, skilled nursing or rehabilitation services in a facility licensed in accordance with MCL 333.1101 – 333.25211 and certified in accordance with 42 C.F.R.§ 483 designed to meet an Enrollee’s needs. Medicaid custodial care is not limited and may exceed 180 days.

B. As set forth in Section 6.11G Contractor will ensure the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) is conducted to determine if an Enrollee meets medical and functional eligibility for Medicaid-reimbursed Nursing Facility Care.

a. Providers must ensure that Nursing Facility beds will be held for the Enrollee for hospital and therapeutic leave days pursuant to the Michigan Medicaid Provider Manual/Nursing Facility Coverages/Special Placements and Agreement.

3.8 Nursing Facility Payment

A. For traditional Medicaid nursing facility days of care, Contractor must negotiate with Nursing Facilities to establish rates.

B. It is the responsibility of the Nursing Facility provider to collect the PPA for traditional Medicaid nursing facility days of care, and the Contractor must reduce reimbursements to Nursing Facility providers equal to the PPA amount each month.

C. The Quality Assurance Supplement (QAS) for traditional Medicaid nursing facility days of care will be paid through a directed payment as approved by CMS through the 42 C.F.R. § 438.6(c) preprint process.

D. Contractor may negotiate coinsurance for days 21 through 100 of a skilled care or rehabilitation day in accordance with federal regulations (42 CFR 422.202(a)(1)).

E. Contractor must, as part of their skilled nursing facility benefit, provide skilled nursing level of care in a long-term care facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

F. When an enrollee has a PEME, Contractor must not reduce reimbursements to Nursing Facility providers equal to the amount of PEME.

3.9 Dental Provider Payment Rules

A. The Contractor is required to pay Medicaid participating dental providers, at a minimum, the Medicaid FFS rate for covered Current Dental Terminology (CDT) codes. Medicare covered services will be paid according to Medicare policy.

3.10 Direct Care Worker (DCW) rates

A. In accordance with MDHHS Numbered Letter 24-59 , Contractor must pay direct care workers providing services as set forth in that

letter at the rate and manner according to its terms as it may be amended or replaced from time to time.

3.11 Hospice Services Not Covered by Medicare.

A. Contractor must provide all authorized and medically necessary Part D and Medicaid services not related to the Enrollee's terminal illness in accordance with Medicaid policy and medically accepted standards of care, including "room and board" when provided in a nursing facility.

3.12 Service Animal Stipend

A. Contractor must provide a twenty dollar ($20) monthly stipend for care and maintenance of a service animal, paid directly to the enrollee when coverage criteria defined in the HIDE SNP chapter of the Michigan Medicaid Provider Manual is met.

   a. The Americans with Disabilities Act (ADA) defines service animals as those that are individually trained to do work or perform tasks for people with disabilities.

   b. This benefit covers dogs and miniature horses that meet the ADA definition of service animal.

   c. This benefit does not include general pets whose sole function is to provide comfort or emotional support.

B. This benefit is included in Medicaid capitation rates.

   a. MDHHS will collect stipend utilization/payment data from D-SNPs annually as procedure codes are unavailable for this benefit, MDHHS will make a template for reporting this information available.

   b. The template will include the following elements: Beneficiary ID, Beneficiary first/last name, amount paid by month, and total annual amount paid.

   c. The reporting period is each calendar year. Submission of the annual service animal stipend report will occur in January of the year following the reporting period as directed by MDHHS.

3.13 Behavioral Health Benefit

A. Contractor must provide all Medicaid behavioral health services not provided by the PIHPs, consistent with Appendix D and MDHHS Medicaid Policy.

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

C. Medicaid specialty services including behavioral health, intellectual/developmental disabilities services and supports, and substance use services must be provided by the PIHP, in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid in Appendix D.

3.14 Access to Services for Enrollees with Behavioral Health Needs

A. Primary Care

a. Contractor must provide primary care training on evidence-based behavioral health service models for Primary Care Providers, such as Screening, Brief Intervention and Referral to Treatment (SBIRT).

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

B. Behavioral Health Care

a. Contractor must ensure access to all behavioral health services covered under this Contract to all Enrollees with behavioral health needs, in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid in Appendix D.

b. MDHHS reserves the right to modify the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid, including but not limited to changing coverage responsibility for mental health services so that responsibility will be determined by the level of Enrollees' needs rather than by the setting in which a service is provided.

3.15 Dental Services for Adults

A. Contractor must demonstrate an enhanced Medicaid network, adequate to provide covered dental services, in accordance with the Provider Network Adequacy Standards and Dental Timely Access Standard grids below.

   a. This network must be included in a provider directory available on Contractor's website and adhere to all network requirements and standards included in Appendix C.

B. If a subcontractor is used to administer dental services, the Dental contract with the subcontractor must include at a minimum, the requirements outlined in this Contract.

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

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

   c. Contractor must ensure Enrollees are aware of how to identify their dental coverage when seeking care from a dental provider and include dental coverage on the single Enrollee ID Card.

   d. The Enrollee ID Card must include identification of dental coverage, and/or the dental vendor's name and a customer service phone number to inquire about dental benefits.

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

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

3.16 Emergency Services

A. When Michigan Medicaid covers emergency services not covered by Medicare or covers a needed service in a greater amount, duration, or scope than Medicare, Contractor must provide these services through Medicaid in accordance with this Contract.

B. Under this Contract, Contractor must cover appropriate cost sharing for Medicare-covered emergency services and medical screening exams consistent with the Emergency Medical Treatment and Active

Labor Act (EMTALA) (42 USC 1395dd(a)). Enrollees must be screened and stabilized without prior authorization.

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

   a. Contractor must cover appropriate cost sharing for Medicare-covered out-of-network or out-of-area Emergency Services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services.

   b. Contractor must cover appropriate cost sharing for Medicare-covered Emergency Services regardless of whether the emergency department provider or hospital notified the Enrollee's PCP or Contractor of the Enrollee's services in the emergency department.

   c. Unless a representative of Contractor or the Enrollee's PCP instructed the Enrollee to seek Emergency Services, Contractor will not be responsible for paying for or covering cost-sharing for non-emergency treatment services that are not authorized by Contractor.

   d. Contractor must cover appropriate cost sharing for Medicare-covered emergency transportation and professional services needed to evaluate or stabilize an Emergency Medical Condition found to exist using a prudent layperson standard.

D. Contractor acknowledges that hospitals offering Emergency Services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an Emergency Medical Condition does or does not exist.

E. Contractor further acknowledges that if an Emergency Medical Condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Enrollee.

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

G. If any services are not covered by Medicare but covered by Medicaid, Contractor must cover such services under this Contract.

H. Contractor must cover (consistent with 42 CFR 422.214) appropriate cost sharing for Medicare-covered post-stabilization care services obtained within or outside Contractor's network that are pre-approved by a Contractor Provider or other Contractor representative.

I. Contractor must cover appropriate cost sharing for Medicare-covered post-stabilization care services, regardless of whether the services were provided in Contractor's network. Even if these services were not pre-approved by Contractor, Provider, or other Contractor representative but administered to maintain the Enrollee's stabilized condition within 1 hour of a request to Contractor for pre- approval of further post-stabilization care services.

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

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

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

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

   d. Contractor's financial responsibility for Medicaid coverage or Medicare cost-sharing for post-stabilization care services not

preapproved ends when any of the following conditions are reached:

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

ii. Contractor 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

3.17 Pharmacy Services

A. For pharmacy services not covered by Medicare, Contractor must provide pharmacy services to Enrollees according to Medicaid Policy and MDHHS-established protocol and in accordance with 42 CFR 438.3(s), Contractor must:

a. For pharmacy services not covered by Medicare, provide coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act that meets the standards for such coverage imposed by section 1927 of the Act as if such standards applied directly to Contractor.

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

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

B. Contractor must operate a Drug Utilization Review (DUR) program through either a Pharmacy and Therapeutics committee or DUR board for the purpose of meeting coverage standards delineated under Section 1927 of the SSA. The DUR program must comply with the requirements described in section 1927(g) of the Act, 42 CFR part 456, subpart K, as if such requirement applied to the Contractor instead of the State and Section 1004 of the Support for

Patients and Communities Act. Contractor's DUR program must include but not be limited to:

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

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

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

d. Include permitted exclusions for Enrollees that are:

   i. In hospice or palliative care.

   ii. Receiving treatment for cancer.

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

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

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

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

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

C. Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug, vitamin or supplement that is covered on the Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members, found at

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmi.primetherapeutics.com%2Fprovider%2Fexternal%2Fmedicaid%2Fmi%2Fdoc%2Fen-us%2FMIRx_medicarepartd_dual_eligible_covered_ndcs.xlsx&wdOrigin=BROWSELINK

This list is updated monthly, and Contractor must update its formulary and point of sale coding to account for changes not less than quarterly. Point-of-sale coding must be updated within seventy-two (72) hours if an emergency change has been requested by MDHHS.

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

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

F. Contractor must provide MDHHS access to Contractor's published formulary to facilitate Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members compliance monitoring.

G. Contractor is required to cover FFS CSHCS NDCs Drug List

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(https://mi.primetherapeutics.com/provider/documents

Fee For Service Drug Coverage) for Enrollees that are also enrolled in CSHCS.

H. Contractor, including Contractor's Pharmacy Benefit Manager (PBM) or its Subcontractors, is prohibited from negotiating any rebates with drug manufacturers for all drugs and non-drug items for which MDHHS has entered into a State supplemental rebate agreement with the manufacturer. If Contractor, its PBM or other subcontractors have an existing rebate agreement with a manufacturer, all covered outpatient drug and non-drug item claims for Medicaid participants for which MDHHS is obtaining State

supplemental rebate must be exempt from such rebate agreements. This applies to both prescription, over-the-counter drugs, and non-drug items such as blood- glucose test strips. The MDHHS Medicaid Provider Manual's Directory Appendix identifies the CMS website listing of drug manufacturers participating in the Medicaid Drug Rebate Program (MDRP). Contractor or its Subcontractors may only negotiate with and accept rebates from in relation to drugs that are not on any supplemental rebate agreement list provided by MDHHS.

I. As directed by MDHHS, Contractor must provide all pharmacy records for prior authorization to facilitate Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members compliance monitoring.

J. Contractor must submit its Pharmacy Benefit Manager (PBM) Contract and Pharmacy policy and procedures upon request as follows:

   a. Executed, dated and current contract.

   b. A process to review physician requests to prescribe any medically appropriate drug covered included in the Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members list.

   c. Include over-the-counter products listed in Section IV.P.4 and 5 as covered by the Medicaid FFS program.

   d. Specify requirements for the use of generic drugs.

   e. Policy and procedures.

K. Contractor must require its pharmacy benefit manager (PBM) or its subcontractors to implement all of the following:

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

   b. Agree to move to a transparent "pass-through" pricing model, in which the pharmacy benefit manager discloses the administrative fee as a percentage of the professional dispensing costs to MDHHS.

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

L. The Contractor's transition of care processes for prescribed drugs shall be consistent with the requirements in Medicare Part D transition guidelines.

M. All non-Part D drugs, therapies, or other services existing in Medicaid at the time of Enrollment will be honored for ninety 90 calendar days after enrollment and will not be terminated at the end of ninety 90 calendar days without advance Notice to the Enrollee and transition to other drug therapies or services, if needed.

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

O. Contractor's pharmacy Encounter Data must include data elements as required by MDHHS Pharmacy 340B policy and claim submission requirements. Upon MDHHS request, Contractor must promptly collect and share submitted Network Provider claim data and drug purchase details for resolution of drug manufacturer 340B rebate disputes.

P. Contractor must have a single Bank Identification Number (BIN)/American National Standards Institute (ANSI) Issue Identifier Number (IIN) and Processor Control Number (PCN)). The BIN/IIN and PCN are listed on the PBM/processor/plan's Payer Sheets for trading partners to know the proper identifiers for routing transactions. Contractor must require that only these billing identifiers be used for claim submission and routing purposes for The MICH Program.

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

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

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

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

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

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

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

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

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

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

reimbursement and purchasing or enhancing health outcomes are permitted.

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

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

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

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

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

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

h. If there is not a provision in the agreement to restrict the PBM from selling pharmacy data, Contractor must require a secure process to be included and followed. If any Michigan Medicaid Contractor pharmacy data is sold, aggregate total amount received by the PBM for Contractor's data must be reported to Contractor at least semi-annually.

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

j. A clause that allows Contractor to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or

defraud the public, as well as unfair or deceptive business practices.

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

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

3.18 Transplant Services

A. Contractor must cover appropriate cost sharing for Medicare-covered costs associated with transplant surgery and care.

B. Related care may include, but is not limited to:

   a. Organ procurement.

   b. Donor searching and typing.

   c. Harvesting of organs, and

   d. Related donor medical costs.

C. Contractor must also cover appropriate cost sharing for Medicare-covered extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, small bowel, and bone marrow including allogenic, autologous, and peripheral stem cell harvesting) must be covered on a patient-specific basis when determined Medically Necessary according to currently accepted standards of care.

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

E. If a Transplant Service is not covered by Medicare but is covered by Medicaid pursuant to this Contract and MDHHS Covered Services, Medicaid will be the primary payer.

3.19 Vaccines and Immunizations

A. Contractor must provide Enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and in accordance with Medicaid Policy.

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

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

D. Contractor must cover or pay applicable Medicare cost sharing for Enrollees who receive vaccines and immunizations at local health departments (LHDs).

a. Contractor must reimburse LHDs for all vaccines and immunizations and associated administration fees regardless of whether a contract exists between Contractor and the LHD.

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

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

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

3.20 Health Promotion and Education

A. Contractor must not charge an Enrollee a fee for participating in health promotion and education programs for Covered Services.

B. Contractor may charge a nominal fee if the Enrollee elects to participate in a program not primarily related to a Covered Service.

3.21 Tobacco Cessation Treatment

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

B. Contractor must pay applicable Medicare cost sharing and or provide tobacco cessation treatment that includes, at a minimum, the following services:

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

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

c. Non-nicotine prescription medications

d. Prescription inhalers and nasal sprays

e. The following over-the-counter agents

i. Patch

ii. Gum

iii. Lozenge

C. Combination therapy – the use of a combination of medications, including but not limited to the following combinations:

a. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)

b. Nicotine patch and inhaler

c. Nicotine patch and bupropion SR

3.22 Coordination for Services Covered Outside this Contract.

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

a. Inpatient hospital psychiatric services (see Appendix D)

b. Outpatient partial hospitalization psychiatric care (see Appendix D)

c. Behavioral health assessment and services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance (see Appendix D)

d. Certain substance use disorder (SUD) services (see Appendix D), including:

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

   ii. Detoxification (see Appendix D)

   iii. Intensive outpatient counseling and other outpatient services

   iv. Methadone treatment and other SUD treatment.

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

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

g. Children's Special Health Care Services (CSHCS) offered by MDHHS.

3.23 Services Prohibited or Excluded under Medicaid

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

   a. Elective cosmetic surgery

   b. Services for treatment of infertility

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

   d. Elective abortions and related services Abortions may be covered if one of the following conditions is met:

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

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

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

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

v. All appropriate forms relating to abortion must be completed by the designated party and Contractor must retain these forms for 10 years. The appropriate forms must also be submitted to MDHHS annually and prior to reimbursement. Contractors must follow the Practitioner section of the MDHHS Medicaid Provider Manual.

3.24 Out-of-Network Reimbursement Rules

A. For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined by 42 CFR §§ 424.101 and 405.400, and this Contract, the health care professional is required to accept as payment in full by Contractor the amounts the health care professional could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS.

a. Under this Contract, Contractor must cover applicable Medicare cost sharing for such out-of-network Emergency or Urgent Care services. However, Contractor is not required to reimburse the health care professional more than the health care professionals charge for that service.

b. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 CFR §§ 412.105(g) and 413.76.

c. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies Contractor in writing that it is billing an amount less than such amount.

d. Contractor may authorize other out-of-network services to promote access to services and continuity of care.

B. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, Contractor will pay out-of-network health care professionals and section 1861(u) providers of services the amount that providers could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 CFR §§412.105(g) and 413.76 for section 1861(u) providers), regardless of the setting and type of care.

C. Under this Contract, Contractor must cover applicable Medicare cost sharing for such out-of-network authorized services.

D. Contractor is required to pay noncontracted providers at Medicaid FFS rates for all properly authorized, medically necessary services for which a clean claim is submitted. Noncontracted providers must comply with all applicable authorization requirements of the Contractor and uniform billing requirements. Enrollees maintain improper billing protections. If Michigan Medicaid has not established a specific rate for the covered service, Contractor must follow Medicaid policy for the determination of the correct payment amount. Nothing in the preceding provisions must restrict the right of the provider and Contractor to negotiate a lower rate of payment.

3.25. Excluded Services

A. Behavioral health, intellectual/developmental disabilities services and supports, and substance use services covered by the Prepaid Inpatient Health Plan (PIHP) and services set forth in Section IV.L are excluded under this Contract.

B. Contractor is responsible for coordinating Medicaid behavioral health services with other covered services and participation in the interdisciplinary care team as outlined in an agreement between the PIHP and Contractor.

C. Community Transition Services are excluded under this Contract.

a. Contractor is responsible for making referrals to the Community Transition Services program when an enrollee meets program criteria as defined in the Community Transition services chapter of the Michigan Medicaid Provider Manual. In the absence of a Community Transition Services Agency in the beneficiary's geographic region, Contractor shall support transitions from

nursing facilities and institutions to the community within the scope of the Contractor's plan benefit package/available services.

4. Medicaid Provider Network

4.1 Network Adequacy

A. Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including the appropriate range of preventive, primary care, and specialty services, behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, 438.52(b), and 438.206, Medicaid Provider Manual, HIDE SNP 1915 b/c waiver applications and under this Contract taking into consideration:

a. The anticipated number of Enrollees.

b. The expected utilization of services, considering the characteristics and health care needs of Contractor's Enrollees.

c. The number and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services.

d. The number of network providers who are not accepting new patients.

e. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.

f. The communication needs of Enrollees; and

g. The cultural and ethnic diversity and demographic characteristics of Enrollees.

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

A. Contractor must:

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

Indian/Alaska Native Enrollees who are eligible to receive services.

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

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

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

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

iv. 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.

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

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

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

(c) 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.).

4.3 Provider Relations and Engagement

A. Contractor must maintain staff to perform Provider relations functions including:

a. Operate a toll-free telephone line for promptly answering calls in an average speed of 20 seconds or three rings.

i. The toll-free telephone line must receive Provider inquiries during normal business hours for a minimum of eight and a half (8.5) hours per day, Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services. However, Contractor and its Providers will not require such verification prior to providing Emergency Services.

b. Publish a Provider Manual(s) to be available on Contractor's website and available electronically or via paper format upon request.

c. Maintain a protocol that will facilitate communication to and from Providers and Contractor, and which must include, but not be limited to, a Provider newsletter and Provider meetings no less than quarterly and as required by MDHHS.

d. Except as otherwise required or authorized by MDHHS or by operation of law, ensure that Providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

e. Work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the QAPI and all other requirements of this Contract.

f. Train Providers including but not limited to Contractor's procedures for authorization and claims payments.

g. Assist Providers to resolve billing and other administrative problems.

h. Respond to Provider concerns about administrative processes.

i. Respond to Provider concerns about Enrollees.

4.4 Medicaid Provider and LTSS Provider Network Standards

A. Contractor must have a sufficient number of Providers to provide all Enrollees with all Covered Services.

B. Contractor's network of Providers must be sufficient in number, mix and geographic distribution to meet the needs of the anticipated enrollment.

C. At a minimum, for each county in the service area, for services provided in Enrollee's home, Contractor must have at least two (2) available providers for each provider type with sufficient capacity to accept Enrollees and otherwise ensure that the Enrollee has a choice of providers.

D. For services provided in the community, Contractor must ensure that 90% of Enrollees have a choice of providers within the required time and distance standards and ratios outlined in Appendix C.

E. Contractor must ensure that 90% of Enrollees approved for long term services and supports receive them within the established maximum wait times. The wait time starts on the day the service has been authorized, or requested if authorization is not required, and ends on the day when the service has been initiated or delivered to Enrollee, including installation and Enrollee education, where needed.

F. Contractor must create a process to monitor, track and measure Enrollee wait times to receive LTSS services and supports, and report it to MDHHS, in a format requested, at least annually or as requested by MDHHS.

G. MDHHS may amend any of the network provider adequacy standards as needed.

H. Contractor must:

a. Require its Network Providers and First Tier Downstream and Related Entities, to meet MDHHS standards for timely access to care and services under this Contract, including standards identified in Appendices D and N, and taking into account the urgency of the need for services.

b. Establish mechanisms to ensure network providers comply with the timely access requirements specified in this contract.

c. Monitor network providers regularly to determine compliance.

d. Require a corrective action from Provider if there is a failure to comply with these requirements.

I. Contractor must establish and conduct an ongoing process for enrolling in their Provider Network willing and qualified providers who meet Contractor's requirements and with whom mutually acceptable provider contract terms, including with respect to rates, are reached.

a. All Providers must be enrolled in CHAMPS to receive reimbursement or compensation with Medicaid funds. Atypical providers who are not eligible to enroll in CHAMPS may be paid with Medicaid funds.

J. Contractor will arrange for personal care services to be provided by independent care providers of the Enrollee's choice, through the use of a fiscal intermediary, an agency of choice, or through a Home Help or other care agency, or through people employed by Contractor, if the individual meets MDHHS qualification requirements, to provide personal care services.

a. Enrollees who currently receive personal care services from an independent care provider may elect to continue to use that provider or select a new provider so long as that provider meets the State qualifications.

b. Contractor must make best efforts to assist independent care providers providing personal care services to Enrollees to join the Provider Network.

c. Contractor will ensure that its contracts, or those of their First Tier, Downstream, and Related entities, for personal care services as defined in Section 1903(l) of the Social Security Act and section 12006 of the 21st Century CURES Act, demonstrate

compliance with Federal requirements regarding the use of Electronic Visit Verification (EVV) in tandem with the MDHHS guidance and requirements.

d. Contractor and their First Tier, Downstream, and Related entities must require compliance in the form of either the existence of an EVV system that meets State requirements or participation in the MDHHS-sponsored statewide EVV system.

e. Contractor will make evidence of compliance available to the State upon request.

f. Contractor and its First Tier, Downstream, and Related entities' contracts must stipulate that the EVV system will support self-directed arrangements and must be minimally burdensome or disruptive to care.

K. Contractor must report personal care providers with mandatory exclusions to MDHHS in accordance with expectations outlined in the Medicaid Provider Manual.

L. Contractor must comply with standards described within the approved 1915(b) and 1915(c) waivers.

a. For providers of overlap services that may be subject to either Medicaid or Medicare network requirements, such as home health and durable medical equipment, the stricter of any applicable standards will apply.

4.5 Network Adequacy Validation

A. Contractor must demonstrate annually, or more frequently as requested by MDHHS, that its Medicaid and LTSS Provider Network meets the network adequacy standards outlined in this contract in Appendix C.

B. State Medicaid standards must be utilized for LTSS and for other services for which Medicaid is exclusive.

C. Annually, as directed by MDHHS, Contractor will submit a list of contracted Medicaid and LTSS network Providers, and results of Contractor's internal network adequacy evaluation for MDHHS' validation in accordance with CMS EQRO NAV protocol.

D. Contractor must submit a list of providers that contain a complete and accurate description of the Provider Network according to the specifications and format delineated by MDHHS.

E. In addition to annual Network Adequacy Validation, MDHHS will monitor access to Medicaid and LTSS services through surveys, utilization data, Grievance and Appeals data to assess if provider network-related corrective actions are needed. Such corrective action may include requiring that Contractor initiates further network expansion.

F. Contractor must submit documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS's standards for access to care:

   a. At the time it enters into this Contract.

   b. On an annual basis as required by MDHHS.

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

4.6 Medicaid Provider Network Exceptions

A. The exception process is used to identify when the supply of providers is such that it is not possible for Contractor to obtain contracts that satisfy MDHHS’s network adequacy criteria for a given county and specific service type.

B. Contractor may request Provider Network Exception to Provider Network Standards based on the following reasons:

   a. No potential providers of a specific service type are available within the network standard

   b. There is only one provider of a specific service type within the network standard and there is no choice available.

   c. The potential provider of a specific service type does not contract with DSNPs.

   d. The potential provider of a specific service type does not meet the qualifications to contract with a DSNP.

e. The provider of a specific service type is sanctioned and therefore ineligible to contract with Contractor.

f. The potential provider of a specific service type does not contract with any organizations or contracts exclusively with another organization.

g. Other reason for MDHHS's consideration.

C. Medicaid Provider Network Exceptions, if any, will be granted at the sole discretion of MDHHS after review of all supporting documentation provided by Contractor.

D. MDHHS will not consider exceptions without sufficient supporting documentation which at a minimum must include:

a. Provider Type and County.

b. Reason(s) for requesting the Provider Network Exception.

c. Description of Contractor's attempts to meet the Provider Network Standard.

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

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

E. If a Provider Network Exception to Provider network 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. Contractor must submit a revised Network Exception request for MDHHS's review annually.

a. For provider types for which Provider Network Exception was granted, Contractor must:

i. Ensure that appropriate processes are implemented to adequately cover services in a timely manner out of network, including paying claims to out-of-network providers and ensuring that enrollees incur no additional costs, as specified in CFR 42 §438.206(b) and §457.1230(a).

ii. Annually report to MDHHS on its use of out-of-network providers to meet Enrollees' necessary medical service needs.

iii. Continue to seek out potential providers to close the provider type network gaps.

iv. Monitor Enrollee access to services offered by the provider type and submit the findings to MDHHS at least annually.

v. During any period in which Contractor does not meet minimum network standards, including for provider types with approved exceptions, Contractor must inform Enrollees of their right to use out-of-network providers for these services or providers.

4.7 Community-Based Organizations

A. Contractor must maintain a network of providers, inclusive of Community Based Organizations (CBOs), Community Health Workers (CHWs) and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders.

5. Management Information Systems

5.1 Management Information System (MIS) Capabilities

A. Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by 42 CFR 438.242 and MDHHS.

B. The system must provide information on areas including but not limited to, utilization, claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

C. Contractor must develop, implement, and maintain policies and procedures that describe how Contractor will comply with the requirements of this section. The information system must have the capability for: Collecting data on Enrollee demographics and special population characteristics on services provided to Enrollees as specified by MDHHS through an Encounter Data system.

a. Supporting Provider payments and data reporting between Contractor and MDHHS.

i. Controlling, processing, and paying Providers for services rendered to Enrollees.

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

b. 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.

iii. Case management.

iv. Provider enrollment.

v. Third Party Liability (TPL) activity.

vi. Claims payment.

vii. Grievance and Appeal tracking, including the ability to stratify Grievance and Appeal by population and track separately (e.g., Enrollees in CSHCS).

5.2 Medicaid Enrollment and Payment Files

A. MDHHS will provide HIPAA-compliant daily and monthly 834 enrollment files to Contractor via the File Transfer Service (FTS).

B. Contractor's MIS must have the capability to utilize the HIPAA-compliant enrollment files to update each Enrollee's status on the MIS.

C. Contractor must load the monthly 834 enrollment audit file prior to the first of the month and distribute enrollment information to Contractor's vendors (e.g., LTSS, HCBS, pharmacy, vision, behavioral health, DME) on or before the first of the month so that Enrollees have access to services.

D. Contractor must reconcile the daily and monthly enrollment files to the monthly payment file within 120 Days of the end of each month.

a. If an issue or error with enrollment files becomes known, MDHHS will communicate the issue, status and working resolution with Contractor.

b. Should the issue or error affect 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.

E. Contractor must ensure that MIS support staff have sufficient training and experience to manage files MDHHS sends to Contractor via the FTS.

5.3 Data Accuracy.

A. Contractor must ensure all Encounter Data is complete and accurate for the purposes of rate calculations, quality and Utilization Management. Contractor must provide for collection and maintenance of sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees.

B. Contractor must ensure data received from Providers is accurate and complete by:

a. Verifying the accuracy and timeliness of the data, including data from Network Providers Contractor is compensating on the basis of Capitation Payments.

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

c. Collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

d. Identifying and tracking Fraud, Waste and Abuse.

C. Contractor must make all collected data available to MDHHS and CMS upon request, including submission of all Enrollee Encounter Data that MDHHS is required to report to CMS under 42 CFR §438.818.

5.4 Automated Contract Tracking System

A. Contractor must utilize the MDHHS Automated Contact Tracking System to submit disenrollment requests for out of area Enrollees

who appear in the wrong county on Contractor's enrollment file and any other administrative requests specified by MDHHS.

5.5 PCP Submission File

A. Contractor must submit a complete file showing all PCP assignments when requested by MDHHS.

B. Contractor must submit the addition, change or deletions within 10 Business Days of the PCP assignment or change.

C. Contractor must submit a complete file showing all PCP assignments when requested by MDHHS.

5.6 Health Information Exchange/Health Information Technology

A. Contractor must support MDHHS initiatives to increase the use of Health Information Exchange and Health Information Technology (HIE/HIT) to improve care management and coordination; reduce Fraud, Waste and Abuse; and improve communication between systems of care.

a. MDHHS reserves the right to revise requirements specified in this section regarding HIE/HIT. This may include, but is not limited to, requirements that Contractor must implement and maintain electronic data systems that would support common information exchange with providers and community-based organizations (CBOs) and further MDHHS community information exchange strategy.

B. Contractor must take all necessary actions to comply with any updated requirements from MDHHS.

5.7 Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

A. MDHHS has established rules and guidelines to advance the adoption and meaningful use of certified EHR technology through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH).

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

C. Contractor must electronically exchange eligibility and claim information with Providers to promote the use of EHR.

D. Contractor must educate Enrollees on Federal interoperability rules including myHealth Button and myHealth Portal.

5.8 Electronic Exchange of Enrollee-Level Information.

A. Contractor must implement and maintain an electronic data system, by which Providers and other entities can send and receive client-level information for the purpose of care management and coordination.

   a. Contractor must ensure capabilities to electronically send applicable assessment data to MDHHS for purposes of care coordination (e.g. LOCD, interRAI, Personal Care Assessment, etc.).

B. The electronic data system must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations.

C. Contractor must ensure Local Health Departments (LHDs) and Children's Multidisciplinary Specialty Clinics (CMDS) that provide and coordinate services for Enrollees in CSHCS have the ability to exchange real-time client-level information for the purpose of care management and coordination.

D. Contractor must ensure PIHPs that provide behavioral health services to Enrollees have the ability to exchange real-time client-level information for the purpose of care management and coordination and reporting quality metrics.

E. Contractor must ensure that transition agencies that provide and coordinate services for Enrollees receiving Community Transition Services have the ability to exchange real-time client-level information for the purpose of care management and coordination.

F. Contractor must ensure capacity to, at a minimum, receive admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination response hospital admissions and readmissions at the plan level and within its provider network.

G. Contractor must ensure capabilities to collect, store, and incorporate clinical quality information into their provider quality measurement and improvement programs to enhance the health plan's capacity to measure and improve the clinical health outcomes of their members.

   a. The proportion of their total provider network and membership used to meet this requirement will be established by Contractor.

6. Care Coordination

6.1 General Requirements.

A. Contractor must offer Care Coordination services to all Enrollees to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD), pharmacy, and LTSS.

B. Contractor must provide the full spectrum of integrated care following requirements of this contract including coordinating care along the continuum of health and wellbeing.

C. Contractor must utilize these principles to maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.

D. Contractor must also include an overarching emphasis on health promotion and disease prevention and must incorporate community-based health and wellness strategies with a strong focus on Health-Related Social Needs (HRSN) and the Social Determinants of Health (SDoH) into its Model of Care (MOC), creating Health Equity and supporting efforts to build more resilient communities.

E. Contractor must ensure that the Enrollee has a PCP appropriate to meet their needs.

F. Contractor will develop and implement a strategy that uses a combination of assessments, referrals, administrative Claims data, etc. to help prioritize and determine the Care Coordination needs of each Enrollee.

G. Contractor is required to have a comprehensive Model of Care as required at 42 CFR 422.101(f) and in accordance with CMS and MDHHS guidance inclusive of the requirements described within this contract that has earned approval from the National Committee of Quality Assurance (NCQA).

H. Contractor will focus on providing services in the most integrated and least restrictive setting.

I. Contractor will have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.

J. Contractor must exhaust the use of community-based services before utilizing institutional settings for LTSS.

K. When needed, Contractor must include an authorized representative familiar with the needs, circumstances and preferences of the Enrollee when the Enrollee is unable to participate fully in or report accurately to the ICT.

L. Contractor will be required to use any MDHHS-required data sharing systems and processes to enable Care Coordination and continuity of care.

M. Care Coordination services will provide for:

   a. A person-centered, outcome-based approach, consistent with Medicare and Medicaid requirements and guidance.

   b. The opportunity for the Enrollee to choose arrangements that support self-determination.

   c. Appropriate access and sharing of information, compliant with all applicable information privacy and security rules including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

   d. The Enrollee’s right to determine the appropriate involvement of all Care Team members including and not limited to providers, family members, caregivers, and other Informal Supports in accordance with applicable privacy standards.

   e. Medication Review and Reconciliation conducted at least annually, when there is a change in condition or transition

between settings, and in alignment with CMS and HEDIS requirements.

6.2 Local Health Departments and CSHCS Coordination

A. Contractor must coordinate care for CSHCS Enrollees in Contractor's Service Area. The coordination must include the following:

   a. Data sharing.

   b. Communication on development of Individual Care Plans.

   c. Reporting requirements

   d. Quality assurance coordination

   e. Grievance and Appeal resolution

   f. Dispute resolution and

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

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

6.3 Transition Agencies and Community Transition Services Coordination.

A. In all regions where there is a Community Transition Agency, Contractor must enter into an agreement with Transition Agencies to coordinate care for Enrollees receiving Community Transition Services in Contractor's Service Area. The agreement must address the following topics:

   a. Data sharing.

   b. Communication on development of Care Coordination Plans.

   c. Reporting requirements.

   d. Quality assurance coordination.

   e. Grievance and Appeal resolution.

   f. Dispute resolution

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

6.4 Collaboration with PIHPs

A. Contractor must establish and maintain Coordinating Agreements with all PIHPs in their Service Area (Coordinating PIHPs) utilizing a standardized template provided by MDHHS that address, at a minimum, processes for Enrollee referrals, access to and coordination of care to ensure continuity of care for Enrollees served by both Contractor and the PIHP, Grievance and Appeal resolution, and other requirements enumerated in this section.

B. All Coordinating Agreements must be submitted to and approved by MDHHS.

C. Contractor must establish key contact personnel in each Coordinating PIHP and ensure that each Coordinating PIHP is aware of Contractor's personnel for ongoing Contractor-PIHP communication and coordination.

D. Contractor must maintain an electronic bidirectional exchange of information with each Coordinating PIHP.

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

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

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

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

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

   (a) Nurse Family Partnership

   (b) Healthy Families America

   (c) Family Spirit

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

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

   (b) Track and confirm referrals to completion.

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

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

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

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

   (a) Medical coordination, including pharmacy and laboratory coordination.

   (b) Data and reporting requirements

   (c) Quality assurance coordination

(d) Grievance and Appeal resolution

(e) Dispute resolution

(f) Transportation

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

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

(i) Service delivery response times

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

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

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

vii. Contractor must present to MDHHS evidence of MIHP referral and care coordination, or evidence of participation in

an alternative evidence-based home visiting model, or refusal of MIHP services, for all MIHP-eligible Enrollees upon request.

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

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

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

6.5 Integrated Care Team

A. Every Enrollee must have access to and input in the development of an Integrated Care Team (ICT) to ensure the integration of the Enrollee's medical, behavioral health, psychosocial care, HRSN, food security, and LTSS. If an Enrollee is unable to be reached or unwilling to participate in the creation of an ICT, then Contractor will demonstrate via documentation attempts to engage with the Enrollee to participate in the ICT.

B. Attempts to engage the Enrollee must be on different days of the week and at different times during the day, including times outside of standard work hours.

C. Contact attempts must be made using different communication mechanisms including and not limited to telephonic outreach, written and mailed communication materials, home visits, or Enrollee portal notifications for Enrollee who have created portal accounts.

D. The ICT will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency,

individualization, accessibility, respect, linguistic and Cultural Competence, and dignity.

E. The ICT will honor the Enrollee's choice about their level of participation. This choice will be revisited periodically by the HIDE SNP Care Coordinator as it may change.

6.6 Integrated Care Team Members.

A. The HIDE SNP Care Coordinator will lead the ICT. It will be the responsibility of the HIDE SNP Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members in accordance with Contractor's NCQA-approved Model of Care.

B. Representatives from entities other than the HIDE SNP that provide services and supports to the Enrollee, when applicable, will be members of ICTs as determined by the enrollee to encourage communication and collaboration between HIDE SNPs and other providers.

C. Membership will include the Enrollee and the Enrollee's chosen allies including HIDE SNP Care Coordinator, and PCP. Additional membership on the ICT may vary, depending on the changing needs of the Enrollee.

D. PCPs may designate a licensed medical professional on their staff who has personal knowledge of the Enrollee's condition(s) and health care needs, to provide input in place of the PCP.

E. The ICT may also include the following persons as needed and available:

a. Family caregivers and natural supports;

b. Primary care nurse care manager;

c. Specialty providers;

d. Personal care providers;

e. Hospital discharge planner;

f. Nursing Facility representative;

g. and others as appropriate.

6.7 Integrated Care Team Responsibilities.

A. The role of ICT is to work collaboratively with the Enrollee and other team members. The HIDE SNP Care Coordinator is responsible to assure the completion of these tasks. ICT members will:

   a. Ensure the Individualized Care Plan (ICP) is developed, implemented, and revised according to the Person-Centered Planning Process as that term is defined and described in 42 CFR §§441.301(c), 441.725(a) and 441.540(a) together with the Enrollee's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT;

   b. Participate in the Person-Centered Planning Process at the Enrollee's discretion to develop the ICP;

   c. Collaborate with other ICT members to ensure the Person-Centered Planning Process is maintained;

   d. Assist the Enrollee in meeting his/her goals;

   e. Monitor and ensure that their part of the ICP is implemented in order to meet the Enrollee's goals;

   f. Ensure the Enrollee's record is updated as needed pertinent to the ICT member's role on the ICT;

   g. Review assessment, test results and other pertinent information;

   h. Address transitions of care when a change between care settings occurs;

   i. Ensure continuity of care requirements are met; and

   j. Monitor for issues related to quality of care and quality of life.

B. The operations of ICTs will vary depending on the needs and preferences of the Enrollee.

   a. An Enrollee with extensive service needs may warrant periodic meetings with input from all ICT members.

   b. An Enrollee with less intense needs may warrant fewer meetings with selected members of the ICT.

   c. The HIDE SNP Care Coordinator is responsible for facilitating communication among the ICT members.

C. It is the responsibility of the HIDE SNP Care Coordinator to share an update regarding the outcome of each ICT meeting available to ICT members within fourteen (14) calendar days.

D. The ICT will adhere to an Enrollee's determination about the appropriate involvement of their medical providers and caregivers, according to HIPAA and, for individuals in substance use disorder treatment, C.F.R. 42, Part 2, and Michigan Public Act 129 of 2014, and Michigan Policy Bulletin MSA 18-44 of 2018.

6.8 HIDE SNP Care Coordinators

A. HIDE SNP Care Coordinators Qualifications

a. HIDE SNP Care Coordinators must have the experience, qualifications and training, including MDHHS-required training, appropriate to the needs of the Enrollee, and Contractor must establish policies for appropriate assignment of HIDE SNP Care Coordinators.

b. HIDE SNP Care Coordinators must be culturally competent and have knowledge of:

i. physical health,

ii. aging and loss,

iii. appropriate support services in the community,

iv. LTSS including State plan personal care, nursing facility, and HCBS options

v. The HIDE SNP Care Coordinator must have knowledge of the Medicaid Provider Manual, as well as current MDHHS and Federal requirements related to care coordination.

vi. frequently used medications and their potential negative side-effects,

vii. depression,

viii. challenging behaviors,

ix. Alzheimer's disease and other disease-related dementias,

x. behavioral health,

xi. substance use disorder,

xii. physical and developmental disabilities,

xiii. issues related to accessing and using durable medical equipment as appropriate,

xiv. Social Determinants of Health

xv. Health Related Social Needs,

xvi. Health Equity,

xvii. Health Disparities,

xviii. available community services and public benefits,

xix. the long- term care ombudsman program.

xx. the "MI Community, Home, and Health Ombudsman (MI CHHO) program,

xxi. quality ratings, as applicable, and information about available options such as nursing facilities, Adult Foster Care, Home for the Aged, and other residential settings.

xxii. applicable legal non-discrimination requirements such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

c. The HIDE SNP Coordinator must be one of the following in Michigan:

i. Licensed registered nurse.

ii. Licensed nurse practitioner.

iii. Licensed physician's assistant.

iv. Licensed Bachelor's prepared social worker.

v. Limited license Master's prepared social worker.

vi. Licensed Master's prepared social worker.

vii. Limited license Bachelor's prepared Social worker.

viii. Clinical Nurse Specialist.

B. HIDE SNP Coordinator Training.

a. Contractor must develop and implement a comprehensive training program for Care Coordination staff including trainings

required by Federal rules, Model of Care requirements, and MDHHS directed topic areas.

b. Contractor must submit training modules, schedules, and evidence of staff development meetings including attendee lists to MDHHS upon request.

c. Contractor must ensure Care Coordinators receive training in each of the following areas:

   i. Person-Centered Planning

   ii. Introduction to HIDE SNPs

   iii. Assessments

   iv. Care Coordination

   v. Critical Incidents

   vi. Advance Directives

   vii. Cultural Competency

   viii Disability Awareness

   ix. Self-Determination

   x. BH Consent

   xi. Emergency Preparedness For Enrollees with Disability and Functional Needs

d. Contractor will participate, train, and report on any training required or offered by MDHHS or its designee. Contractor must comply with any frequency requirements established by MDHHS related to required training topics.

C. HIDE SNP Care Coordinator Responsibilities

a. The HIDE SNP Care Coordinator will be responsible for Care Coordination for each Enrollee.

b. The Enrollee must be provided information on how to contact their Care Coordinator.

c. The HIDE SNP Care Coordinator will:

   i. Conduct the Health Risk Assessment

   ii. Assure the Person-Centered Planning Process is complete

iii. Prepare the Individualized Care Plan

iv. Coordinate care transitions, v. and lead the ICT

d. The HIDE SNP Care Coordinator will be responsible for the following activities, which may not be delegated to other individuals unless specified.

e. For activities that may be delegated, the HIDE SNP Care Coordinator must supervise the activity and be informed of the activity for the purpose of member and provider communications, including ICT discussions. Activities include:

i. Support an ongoing Person-Centered Planning Process;

ii. Assess clinical risk and needs including HRSN and the impact of SDoH by conducting an assessment process that includes a Health Risk Assessment and completion of or referral for additional assessments (as appropriate);

iii. Facilitate timely access to all Medicare- and Medicaid-covered services including, but not limited to, primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the Enrollee, including referrals to address any physical or cognitive barriers or referrals to the PIHP (scheduling appointments or transportation may be delegated);

iv. Make referrals to address any physical or cognitive barriers or referrals to the PIHP;

v. Create and maintain an electronic Enrollee health record for each Enrollee to manage communication and information regarding referrals, transitions, and care delivery;

vi. Facilitate communication among the Enrollee's providers through the use of the Care Coordination Platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence (may be delegated);

vii. Ensure that the ICT is notified of the Enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;

viii. Facilitate face-to-face and in-person meetings, conference calls, and other activities of the ICT as needed or requested by the Enrollee;

ix. Facilitate direct communication between the provider and the Enrollee or the Enrollee's authorized representative and/or family or informal supports as appropriate (may be delegated);

x. Facilitate Enrollee and family education;

xi. Coordinate and communicate, as applicable, with First Tier Downstream and Related Entities (FDR) and other external entities that provide services and supports to the Enrollee to ensure timely, non-duplicative supports and services are provided;

xii. Develop, with the Enrollee and ICT, following the Person-Centered Planning Process, an ICP specific to individual needs and preferences, and monitor and update the ICP at least annually or following a significant change in needs or other factors;

xiii. Facilitate referrals to community resources (e.g. housing, food, energy assistance programs) to meet ICP goals (may be delegated);

xiv. Perform ongoing Care Coordination;

xv. Monitor the implementation of the ICP with the Enrollee, including facilitating the Enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;

xvi. Advocate with or on behalf of the Enrollee as needed, to ensure successful implementation of the ICP;

xvii. Support transitions in care when the Enrollee moves between care settings including:

(a) The HIDE SNP Care Coordinator will contact the Enrollee once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the ICP to include additional supports and services to remain in or return to the community.

(b) The HIDE SNP Care Coordinator will ensure immediate and continuous discharge planning, including electronic and verbal communication with the Enrollee and ICT members following an Enrollee's admission to a hospital or Nursing Facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the Enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the Enrollee has all necessary medications or prescriptions upon discharge, and conducting follow-up with the Enrollee and/or caregiver.

(c) The Care Coordinator must make every effort to ensure that HCBS are in place upon hospital discharge to avoid unnecessary Nursing Facility placements. The Care Coordinator must be able to arrange for expedited assessments and other mechanisms to assure prompt initiation of appropriate HCBS. If the Enrollee is being discharged from a Nursing Facility or hospital, the Care Coordinator must coordinate efforts with the Nursing Facility social worker, discharge planner, CTS Transition Navigator when applicable, or other staff to ensure a smooth transition.

(d) Evaluating Section Q of the Minimum Data Set (MDS) for Enrollees currently in a Nursing Facility and discussing options for returning to the community, revising the ICP and transitioning the Enrollee to the most integrated setting or making at referral to Community Transition Services when applicable.

(e) The HIDE SNP Care Coordinator will inform the Enrollee of their right to live in the most integrated setting, inform the Enrollee of the availability of services necessary to support their choices, and record the home and community-based options and settings considered by the Enrollee.

(f) Engage in other activities or services needed to assist the Enrollee in optimizing their health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and

advocacy agencies, as appropriate; and other modalities to improve health status;

(g) Assist with the timely completion of the Medicaid eligibility redetermination process to prevent the loss of benefits (may be delegated); and

(h) The HIDE SNP Care Coordinator will ensure appropriate assessments are conducted for Enrollees with identified LTSS needs. The HIDE SNP Care Coordinator must collaborate with the applicable PIHP coordinator or identified behavioral health representative as defined in the Coordinating Agreement between Contractor and the PIHP in Section 6.4 D.

(i) If the Enrollee has need of LTSS, the HIDE SNP Care Coordinator will collaborate with the Enrollee's chosen LTSS representative(s), as applicable, when the Enrollee has received LTSS within the last twelve (12) months or a new Enrollee request or is identified as having potential need for LTSS.

D. HIDE SNP Care Coordinator Assignments and Change Requests.

a. Contractor must allow the Enrollee or their authorized representative choice in HIDE SNP Care Coordinator.

b. Contractor must ensure every Enrollee has a HIDE SNP Care Coordinator with the appropriate experience and qualifications based on the Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

c. Contractor must have a process to ensure that an Enrollee or their authorized representative is able to request a change in their HIDE SNP Care Coordinator at any time including a process for the transition from one HIDE SNP Care Coordinator to another.

d. Contractor must establish policies for appropriate assignment of HIDE SNP Care Coordinators to align with the Enrollee's known or expressed cultural, religious, linguistic, and ethnic preferences by considering the knowledge and experience of the HIDE SNP Care Coordinator.

e. Contractor must provide a timely written Notice to an Enrollee or their authorized representative when there is a change in their HIDE SNP Care Coordinator.

f. The Enrollee must be notified in writing within two weeks of the reassignment of the Care Coordinator. The notification must include the name and contact information for the new Care Coordinator. This applies to both Enrollee (also legal representative or guardian) requested changes and Contractor related changes.

E. HIDE SNP Care Coordinator Caseloads

a. There is a mandatory limit on Care Coordinator caseloads based on a point system:

i. Each low-risk Enrollee = 2 points.

ii. Each medium-risk Enrollee = 5 points.

iii. Each high-risk Enrollee = 10 points.

b. The caseload must not exceed 600 points per Care Coordinator.

c. Contractor must establish processes to minimize Enrollee reassignments as part of meeting Care Coordinator caseload limit requirements, e.g., assigning members so that Care Coordinators are not at or close to the maximum point limit.

d. This caseload limit is subject to review by MDHHS and may be modified from time to time.

e. These caseload limits include unable to reach and unwilling to participate Enrollees on Care Coordinator caseloads. Contractor must ensure adequate staffing to meet the needs of the program and beneficiaries without exceeding MDHHS defined ratio.

f. The HIDE SNP Care Coordinator must maintain contact with Enrollees at the frequency specified in this contract, with more frequent interactions as appropriate, based on the Enrollee's needs.

g. If Contractor is unable to comply with Care Coordinator caseload ratio requirements due to constraints posed by being located in a Region with a County that is classified as Rural or CEAC by CMS, it may make a request for a rural exception. Requests for rural

exceptions must be submitted to Contractor's contract manager and must include, at minimum, the following information:

i. Overview of compliance Issue.

ii. Barriers keeping Contractor from compliance.

iii. Steps taken to attempt to come into compliance.

iv. Steps taken to mitigate effects of noncompliance on members.

h. MDHHS will consider requests for rural exceptions and determine flexibilities allowed on a case-by-case basis.

i. Contractor must regularly monitor and report Care Coordinator caseload data in accordance with MDHHS requirements.

j. Compliance with care coordinator caseload limits must be in compliance with Medicaid policy as set forth in The Medicaid Provider Manual.

F. Requirements for HIDE SNP Care Coordinators Who Serve Enrollees with HCBS Needs.

a. In addition to meeting the basic Care Coordinator qualifications described in Section VII.G.1 Care Coordinators serving Enrollees with HCBS needs must:

i. Have knowledge of HCBS including familiarity with current CMS HCBS regulations.

ii. Be familiar with the HIDE SNP waiver services and 1915c application requirements.

iii. Be familiar with Self-Determination including how to implement self-directed service arrangements.

iv. Be familiar with HCBS settings requirements and processes to ensure compliance with requirements as detailed in the HIDE SNP 1915c waiver application and HIDE SNP Chapter of the Michigan Medicaid Provider Manual.

v. Be able to provide information regarding the quality ratings and licensure status, if applicable, of available residential options.

vi. Be knowledgeable about risk factors and indicators of and resources to respond to and report abuse, neglect, exploitation and other critical incidents.

vii. Have experience conducting LTSS needs assessments.

viii. Have familiarity with the Nursing Facility Level of Care Determination (LOCD).

ix. Must be knowledgeable about eligibility requirements for the HIDE SNP HCBS waiver.

x. Must be knowledgeable about the processes for HIDE SNP HCBS waiver enrollment and disenrollment as detailed in the HIDE SNP Chapter of the Michigan Medicaid Provider Manual.

G. HCBS Care Coordination Contractor Responsibilities.

a. Contractor will be responsible to provide, directly or contractually, the following HCBS Care Coordination services:

i. Support an ongoing Person-Centered Planning Process.

ii. Assist the Enrollee to take a lead role in the Person-Centered Planning Process'

iii. Provide information to the Enrollee and ICT.

iv. Communicate and collaborate with the PIHP, CMSHP, or other BH providers as appropriate, when BH, SUD, or I/DD needs are identified in the HRA.

v. Participate in the assessment process as needed, including conducting the HRA specific to the Enrollee's needs

vi. Participate on the Enrollee's ICT.

vii. Assist in the development, with the Enrollee and the ICT, of an ICP.

viii. Ensure optimal utilization of information and community supports.

ix. Arrange services as identified in the ICP.

x. Update the Enrollee health record with current Enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery.

xi. Monitor service implementation, service outcomes, and the Enrollee's satisfaction.

xii. Assist the Enrollee during transitions between care settings, including full consideration of all options.

xiii. Advocate for the Enrollee and support self-advocacy by the Enrollee.

b. Contractor must ensure individuals contracted to conduct the Care Coordination activities in Section VIII.B.1.e meet the qualifications in Section VIII.B.1 of this contract.

c. if HCBS Care Coordination activities in Section VIII.B.1 of this contract are sub-contracted, the sub-contracted care coordination activities must supplement and not supplant the role of the HIDE SNP Care Coordinator.

6.9 Coordination Tools

A. Contractor will employ a care coordination platform, supported by web-based technology, that allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.

B. Contractor will be required to share information with enrollees, providers (including LTSS and BH providers), and other Contractors as appropriate through its care coordination platform.

C. To minimize the duplicate data entry burden on providers that have already invested in certified electronic health records and who have or will soon achieve meaningful use stage one, two, or three compliance, Contractor will also support automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats.

D. Contractor's care coordination platform will:

a. Manage communication and information flow regarding referrals, care transitions, and care delivery.

b. Facilitate timely and thorough coordination and communication among Contractor, the primary care provider, and other providers.

c. Provide prior authorization information for services.

E. The approved electronic care coordination platform will generate and maintain an Electronic/enrollee Health Record including:

   a. Current integrated condition list.

   b. Contact information for the HIDE SNP Care Coordinator and ICT members.

   c. Current medications list.

   d. The date of service and the name of the provider for the most recently provided services.

   e. Historical and current utilization and Claims information.

   f. Historic Medicaid and Medicare utilization data provided by MDHHS, CMS, and other sources.

   g. Health Risk Assessments, Additional Assessments, and Reassessments.

   h. Service outcomes, including specialty provider reports, lab results, and emergency room visits.

   i. ICP.

   j. Notes and correspondence across provider settings.

F. The care coordination platform will allow HIDE SNP Care Coordinators, and providers to post key updates and notify ICT members.

G. Contractor will maintain the care coordination platform and address technological issues as they arise.

H. Contractor is responsible for granting and monitoring access to appropriate ICT members.

I. Contractor will provide ICPs and other items in the enrollee health record in paper format to the Enrollee upon request.

J. Contractor will verify the accuracy of the enrollee health record and amend or correct inaccuracies. Corrections or amendments must be dated and attributed to the person making the change.

K. Contractor will have a mechanism to alert ICT members of emergency department use or inpatient admissions using the electronic care coordination platform or other methods such as telephonic notification.

6.10 Health Promotion and Wellness Activities.

A. Contractor must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers.

B. The focus and content of this information must be relevant to the specific health status needs, including HSRN as well as the common risk factors and SDoH that impact the Medicare- Medicaid population.

C. Health promotion and disease prevention services must be offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population.

D. Contractors must ensure Enrollees have access to evidence-based/best practices educational and wellness programs.

E. Interpreter services must be available for Enrollees who are not proficient in English.

F. Examples of health promotion and wellness topics include, but are not limited to, the following:

a. Chronic condition self-management;

b. Smoking cessation;

c. Nutrition;

d. and Prevention and treatment of alcohol and substance use.

6.11 Enrollee Stratification, Assessments, and Individualized Care Plan (ICP).

A. General Requirements

a. Contractor will develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative Claims data, etc. to help prioritize and determine the level of Care Coordination needed by each Enrollee.

b. Contractor may also choose to use existing predictive modeling software to support the stratification process but will not be required to do so.

c. Within fifteen (15) calendar days of Enrollment, Contractor must review all available program level data and utilization data to

assign initial risk stratification to prioritize outreach and to determine the need for in-person assessments and care coordination activities.

d. Initial and ongoing stratification decisions must be based on all available program level data, utilization data, and assessment data including and not limited to enrollee demographics, physical, behavioral, LTSS, and other medical conditions, functional status, care patterns, resource utilization data, SDoH, HRSN, food security, and the Enrollee's risk for long term care institutionalization or avoidable hospitalization.

e. The following populations are automatically stratified as high risk:

   i. Enrollees receiving services in the Habilitation Supports Waiver;

   ii. Enrollees receiving services in the HIDE SNP HCBS waiver;

   iii. Enrollees transitioning to Contractor from the MI Choice waiver;

   iv. Enrollees transitioning to Contractor from PACE;

   v. Enrollees who are within their first ninety (90) days in Contractor after transitioning from Home Help;

   vi. Enrollees who are transitioning from a nursing facility to the community;

   vii. Enrollees who are receiving personal care services and meet NFLOCD but are not enrolled in the HIDE SNP HCBS waiver;

   viii. Enrollees with unmet needs due to low or no access to needed resources such as caregiver support, housing, food, transportation, and shelter;

   ix. Enrollees who have had five (5) or more hospitalizations in the last 12 months related to uncontrolled conditions;

   x. Enrollees who have had six (6) or more emergency department visits within the last 12 months; and

   xi. Enrollees who had a hospitalization or emergency department visit with a primary diagnosis related to behavioral health

within the last 12 months, until the condition(s) has stabilized.

xii. Contractor will determine the parameters and definitions for other Enrollees defined as high risk as well as definitions for low or moderate risk Enrollees.

B. Heath Risk Assessments (HRAs)

a. Each Enrollee must receive, and be an active participant in, a timely HRA of medical, behavioral health, psychosocial, SDoH, HRSN, and LTSS needs completed by the HIDE SNP Care Coordinator, using the standardized Health Risk Assessment Tool (HRAT) required by MDHHS, unless one of the following circumstances applies:

i. An Enrollee may choose to decline an assessment. Should that occur, Contractor will honor and document the Enrollee's decision.

b. In instances where Enrollees are unable to be reached for ongoing assessments, the plan will need to leverage available information (e.g. MDHHS 270/271 process, 834s, the beneficiary, CMS, other sources, etc.) to conduct outreach and document attempts. Contractor must attempt to reach the Enrollee at least three times within the first ninety (90) days of enrollment.

i. Contractor must continue to attempt to contact Enrollees who were classified as unable to reach after the first ninety (90) days of Enrollment.

ii. One contact attempt must be made at least monthly after the first ninety (90) days. The contact attempts must be informed by claims data analysis and regular coordination with providers and First Tier, Downstream, and Related Entities, which must also be conducted monthly.

iii. Telephonic outreach attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.

iv. Contact attempts must be made using different communication mechanisms including and not limited to telephonic outreach, written and mailed communication

materials, home visits, or Enrollee portal notifications for Enrollees who have created portal accounts.

v. Outreach attempts must be documented in the Enrollee's record.

c. Contractors must use community resources where possible to identify and engage Enrollees.

d. The HIDE SNP Care Coordinator will identify, through the HRA, Enrollees who may require institutional level of care and Enrollees with BH, SUD, and I/DD needs.

i. The HIDE SNP will utilize the DSM-5 screening tool within the HRA to identify individuals with BH, SUD, and/or I/DD needs.

ii. When the results of the screening indicate a need for further follow-up the HIDE SNP must make a referral to the PIHP within 5 days of identifying the need.

iii. If an Enrollee refuses a referral to the PIHP for additional evaluation, the HIDE SNP must document this in the enrollee health record.

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

f. Contractor will perform the Health Risk Assessment using the standardized Health Risk Assessment Tool (HRAT) provided by MDHHS to assess each Enrollee's current health, welfare, functional needs, SDoH impacts, HRSN, quality of life, strengths, supports, and risks.

g. Contractor may include additional MDHHS-approved questions and domains as appropriate.

h. Contractor will coordinate with the PCP to ensure that Enrollees with complex medical needs identified in the HRA have further follow-up relevant to these needs.

i. The HRA will be completed by the HIDE SNP Care Coordinator employed or contracted with Contractor who is accountable for providing Care Coordination services.

ii. Contractor retains responsibility and accountability for utilization management functions, Appeals, and approval of services.

iii. The Care Coordinator role cannot be delegated through contract or other means to Long Term Supports and Services providers who are otherwise responsible for providing services to Enrollees, such as nursing facilities.

i. Contractor will invite the appropriate representative from the PIHP, or entity providing LTSS, or Nursing Facility staff as appropriate to participate in conducting the Health Risk Assessment if the Enrollee has been active in the PIHP or LTSS system during the previous twelve (12) months or is currently residing in a Nursing Facility.

i. Family members or other individuals may also be included in the HRA process to the extent desired by the Enrollee.

j. Contractor is encouraged to conduct all assessments in-person and must conduct the HRA in-person for those Enrollees with immediate needs or stratified as high risk.

k. Contractor will use the results of the HRA to confirm the appropriate acuity or risk stratification level for Enrollee Care Coordination assignments and to determine the need for an Additional Assessment as referenced in Section 6.11D below.

l. The HRA and Additional Assessments, if applicable, will be used to develop the ICP.

m. Contractor will make referrals to PIHPs according to the process identified in its MDHHS-approved Coordinating Agreements for Enrollees identified as having BH, SUD, and/or I/DD needs.

n. Contractor will not refer Enrollees to PIHPs who are residing in a Nursing Facility at the time of the HRAT completion, who are identified with BH, SUD and/or I/DD needs, and are receiving services through the OBRA PASRR program.

i. If unmet needs are identified for this population, Contractor will coordinate needed care and service with the Nursing Facility staff and the local CMHSP responsible for the PASRR program and behavioral health service delivery to Enrollees in the Nursing Facility.

ii. The Enrollee will continue to receive any services in any existing care/service plan prior to completion of the HRA.

iii. Contractor will adhere to all transition requirements for services in order to ensure continuity of care as described in Section IX.F. Health Risk Assessments will be documented in the enrollee health record and results used in the development of the ICP.

C. Timing of Health Risk Assessments.

a. HRAs will be completed within ninety (90) calendar days of Enrollment.

b. Enrollees identified with immediate needs or as having high risk must have HRAs completed earlier than ninety (90) calendar days from Enrollment, as appropriate.

c. The HIDE SNP Care Coordinator is responsible for assuring completion of further assessment for Enrollees with medically complex conditions.

d. Contractor is prohibited from completing HRAs by mail. Contractor may mail HRAs only with prior approval from MDHHS.

e. The HIDE SNP Care Coordinator is encouraged to conduct the Health Risk Assessment in person. Enrollees identified with immediate needs or as having high risk will have assessments completed in person.

f. Contractor must ensure that a Reassessment and an ICP update are performed:

i. At least every twelve (12) months after the HRA completion date;

ii. When there is a change in the Enrollee's health status or needs; or

iii. As requested by the Enrollee, their caregiver or authorized representative, or their provider if they feel there has been a functional/health change.

g. Contractor will analyze utilization data of all Enrollees monthly to identify acuity and risk level changes. Reassessments will be completed when utilization data indicates a significant change in

the enrollee's acuity and risk status. ICP and interventions will be updated and documented in the enrollee health record.

h. Contractor must identify Enrollees through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and Contractor personnel.

i. Contractor must notify PCPs of Enrollment of any Enrollee who has not completed an HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor must encourage PCPs to conduct outreach to these Enrollees and to schedule visits.

j. Contractor must collaborate with clinics, hospitals, or Urgent Care centers to identify Enrollee contact information for Enrollees Contractor has not been able to contact.

D. Additional Assessments.

a. Additional Assessments will be conducted by appropriately trained and knowledgeable licensed health professionals who have experience working with individuals who have HCBS, or LTSS service needs. The licensed health professional is not required to meet Care Coordinator credentials or other specified credentials unless indicated otherwise in this section.

b. Any Additional Assessment that may have been completed prior to Enrollment by appropriately trained and licensed health professionals may be adopted if it is not past the Reassessment date. The Additional Assessment must be reviewed to determine if it is complete, accurate and appropriate for the Enrollee's current status.

c. Adoption of Additional Assessments completed by appropriately trained and licensed health professionals utilizing other assessment tools which are not past the Reassessment date is allowed as long as the assessment addresses the same domains identified in the corresponding required Additional Assessment.

d. Additional Assessments will be conducted in person, as soon as the Enrollee's condition warrants and no later than twenty (20) calendar days from the date the need for an assessment was identified by Contractor, unless a different timeframe is identified in this section.

i. If an individual or entity external to Contractor will conduct the additional assessment(s) Contractor must make a referral to the individual or entity within five (5) business days from the date the need for an assessment was identified by Contractor.

e. Additional Assessments will be documented in the enrollee health record and results used in the development of the ICP.

f. Contractor will ensure that the following Additional Assessments are conducted as appropriate for Enrollees based on needs identified during the HRA.

i. InterRAI home care assessment (interRAI HC/iHC) for Enrollees needing waiver services (interRAI HC data must be electronically transmitted to the State as directed by MDHHS).

ii. The Personal Care Assessment for Enrollees demonstrating ADL needs identified in the HRA, Enrollees transitioning from the Home Help program, Enrollees with personal care flag in CareConnect360, Enrollees with identified personal care need in other MDHHS data exchange, or Enrollees with a history of personal care services from another HIDE SNP.

iii. Nursing Facility Level of Care Determination for Enrollees demonstrating Nursing Facility level of care needs, including HCBS waiver service needs identified during the HRA to determine eligibility for those services as well as Medicaid Nursing Facility services.

iv. Other assessments as may be approved by MDHHS.

E. InterRAI HC

a. InterRAI HC assessment data must be electronically submitted to MDHHS as directed for purposes including but not limited to the passive LOCD redetermination process detailed in the Nursing Facility Level of Care Determination Chapter of the Michigan Medicaid Provider Manual.

F. Personal Care Assessment.

a. The Personal Care Assessment will be conducted, as necessary, to determine eligibility for State Plan Personal Care Services.

b. MDHHS will provide Contractor with the Personal Care Assessment tool specifications to determine time and task for the Enrollee.

c. Contractor will adopt any existing assessment tool and the time and task determined by that tool for an Enrollee transitioning from the Home Help program or another HIDE SNP.

d. MDHHS will make available the time, task, and provider details through CareConnect360 or other data exchange.

e. Contractor must comply with supplemental guidance related to Personal Care Services and the Personal Care Assessment located in the HIDE SNP Chapter of the Michigan Medicaid Provider Manual.

G. Michigan Medicaid Nursing Facility Level of Care Determination.

a. In order to determine eligibility for HCBS waiver or Medicaid Nursing Facility Services Contractor will ensure that the LOCD tool is conducted as necessary for Enrollees demonstrating Nursing Facility level of care needs identified in the HRA, for those Enrollees residing in a nursing facility at the time of enrollment, and for those Enrollees enrolled on the HIDE SNP HCBS waiver.

i. The entity completing the tool will record the findings in CHAMPS for MDHHS to make final eligibility determinations and authorize appropriate Tier assignment and Contractor Capitation Payment.

ii. Final eligibility determinations for LOCD will be completed by MDHHS, or by an independent contracted entity, as directed by MDHHS.

b. Contractor must ensure compliance with the requirements for persons authorized to conduct the LOCD located in the Nursing Facility Level of Care Determination Chapter of the Michigan Medicaid Provider Manual.

i. A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee through a verification review (LOCD-VR) to determine if the LOCD was conducted properly according to policy and resulted in the correct determination of eligibility.

ii. The entity that conducted the LOCD is required to submit all relevant documentation used to support the LOCD in a timeframe and manner directed by MDHHS.

iii. MDHHS or its designee will review every HIDE SNP LOCD door 0 (does not meet criteria for doors 1-8), make the determination of eligibility and issue an Adverse Benefit Determination Notice and appeal rights to Enrollee as applicable.

iv. If an Administrative Appeals Hearing is required, the HIDE SNP will be notified and required to participate as a witness.

c. Contractor must ensure compliance with supplemental guidance related to LOCD located in the HIDE SNP and Nursing Facility Level of Care Determination Chapters of the Michigan Medicaid Provider Manual.

H. Timing of the LOCD tool.

a. The LOCD must be conducted before the provider is eligible for Medicaid reimbursement for services rendered to the beneficiary.

i. The LOCD must be conducted prior to or on the day of NF admission or HCBS waiver enrollment.

ii. If the enrollee resided in a nursing facility at the time of enrollment or initial HRA, an existing LOCD may be adopted. The D-SNP must ensure that the existing LOCD reflects the enrollee's present condition. If the existing LOCD does not reflect the Enrollee's present condition, the D-SNP must ensure a new LOCD is conducted. The Freedom Of Choice (FOC) form must be completed when adopting an LOCD if there is a change in program/provider/or a new admission/enrollment.

I. Reassessments

a. Contractor is responsible for ensuring that an annual Reassessment for each Enrollee (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within twelve (12) months of the last Health Risk Assessment.

b. If prior to the annual Reassessment, the Enrollee experiences a major change impacting health status, Contractor is required to reassess the Enrollee and review and revise the ICP with members of the ICT as needed.

c. Contractor is responsible to complete a Reassessment as often as desired by the Enrollee and update the ICP with members of the ICT as needed.

d. Contractor is responsible for developing a Reassessment strategy that includes conducting State defined Reassessments as direct by MDHHS in the HIDE D-SNP Chapter of the Michigan Medicaid Provider Manual Contractor is encouraged to conduct all reassessments in-person and must conduct reassessments in-person when required by MDHHS.

e. Additional Assessments will be repeated according to the timeframe indicated in the HIDE Chapter of the Michigan Medicaid Provider Manual.

f. For Enrollees receiving Nursing Facility level of care services or 1915(c) waiver services, the Reassessment must confirm that the Enrollee continues to meet the Michigan Medicaid LOCD standards. If the standards are not met, Contractor will initiate planning for transitioning the Enrollee to more appropriate supports and services including making a referral to the Community Transitions Services program as applicable.

g. Reassessments will be documented in the enrollee health record and results used in the development of the ICP.

J. Individualized Care Plan (ICP).

a. The HIDE SNP Care Coordinator, the Enrollee, their family, caregiver or authorized representative, providers, and other ICT members must develop a comprehensive, person-centered, written ICP for each Enrollee.

b. Contractor must use a standardized template for ICPs that will be developed and approved by MDHHS and Contractor. This requirement will not be implemented in 2026.

c. Unless the Enrollee refuses, the meeting to develop the ICP will be conducted in person at a time and location convenient to the Enrollee.

i. If the Enrollee refuses the ICP, at a minimum the HIDE SNP Care Coordinator must provide their contact information to the Enrollee and re-visit the refusal at the time of Reassessment or a change of condition.

ii. If the Enrollee is unable to be reached or unwilling to participate in the ICP development, then Contractor will create an ICP using pertinent available information.

iii. All refusals must be documented in the enrollee health record.

d. Contractor must attempt to reach the Enrollee at least three (3) times within the first ninety (90) days of Enrollment to complete ICP.

i. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.

ii. Contact attempts must be made using different communication mechanisms including and not limited to telephonic outreach, written and mailed communication materials, home visits, or Enrollee portal notifications for Enrollee who have created portal accounts.

iii. Outreach attempts must be documented in the Enrollee's record.

e. Contractor must complete the initial ICP within ninety (90) calendar days of Enrollment.

f. Existing person-centered service plans or plans of care can be incorporated into the ICP.

g. Contractor must review the adopted plan with the Enrollee to determine if revisions are necessary to address the Enrollee's prioritized goals and meet the Enrollee's needs.

h. The ICP must be contained in the enrollee health record and shared with the Enrollee and the ICT.

i. Only ICPs developed with the participation from Enrollee or Legal Representative, as evidenced by ICP signature, will be counted toward ICP completion Quality Measures.

K. ICP Monitoring.

a. Contractor will review the ICP with the Enrollee to ensure it continues to meet the Enrollee’s needs and is updated accordingly.

b. Refusals to participate in the ICP review and the reason for the refusal must be documented in the enrollee's health record.

c. Contractor must review ICPs of high-risk Enrollees with the Enrollee at least every thirty (30) calendar days.

d. For enrollees who have been designated high-risk, the HIDE SNP Care Coordinator will complete an in-person visit with the Enrollee to review the ICP at least quarterly.

    i. The other monthly ICP reviews during each quarter may be conducted as an in-person, telephonic or Face-to-face visit with the Enrollee.

e. Contractor must review ICPs of moderate-risk Enrollees with the Enrollee at least every ninety (90) calendar days.

    i. At minimum, at least every other ICP review will be an in-person visit with the Enrollee. The other quarterly ICP reviews may be conducted as an in-person, telephonic or telepresence visit with the Enrollee.

f. Contractor must review ICPs of low-risk Enrollees with the Enrollee at least every one hundred and eighty (180) calendar days.

    i. The Enrollee must be offered the opportunity for an in-person ICP review with the HIDE SNP Care Coordinator.

    ii. If the Enrollee does not wish to have an in-person ICP review, the HIDE SNP Care Coordinator may conduct a face-to-face or telephonic visit with the Enrollee.

    iii. The HIDE SNP Care Coordinator will discuss with the Enrollee the Enrollee’s options for ICP reviews (in person, telephone, face-to-face meetings). Contractor must document these discussions in the enrollee health record.

g. Contractor must update the Enrollee’s ICP at least annually, and more frequently if conditions warrant, or if an Enrollee requests a change.

h. The Individualized Care Plan must:

i. Focus on supporting the Enrollee to achieve personally defined goals in the most integrated setting;

ii. Be developed following MDHHS principles for person-centered planning outlined in the HIDE SNP Chapter of the Michigan Medicaid Provider Manual;

iii. Include consideration of the Enrollee's cultural values and the communication needs and preferences of the Enrollee;

iv. Include the Enrollee's preferences for care, services, and supports;

v. Include the Enrollee's prioritized list of concerns, goals and objectives, and strengths;

vi. Include specific providers, supports and services including amount, scope, and duration;

vii. Include a summary of the Enrollee's health status;

viii. Include the plan for addressing concerns or goals and measures for achieving the goals;

ix. Include person(s) responsible for specific interventions, monitoring, and Reassessment including backup caregivers for individuals receiving in-home supports and services in the event of an emergency;

x. Include the due date for the interventions and Reassessment;

xi. Include a plan to address SDoH and HRSN including food security as necessary, identified in the Health Risk Assessment.

xii. Be signed by the Enrollee and the Enrollee's assigned Care Coordinator.

i. Contractor must comply with supplemental guidance related to ICP content and signature requirements within the HIDE D-SNP Chapter of the Michigan Medicaid Provider Manual.

j. Contractor must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Policy which can be found in the HIDE SNP chapter of the Michigan Medicaid Provider Manual. The person-centered planning process must include coordination of services between settings of care

which includes appropriate discharge planning for short and long-term hospitalizations.

L. Self-Determination.

a. Contractor will offer Enrollees the opportunity to use arrangements that support Self-Determination for appropriate waiver services.

b. Contractor will establish and submit policies and procedures to MDHHS that develop and implement mechanisms for Enrollees to access arrangements that support Self-Determination consistent with MDHHS requirements and guidance.

c. These policies and procedures will include provisions to:

i. Inform the Enrollee of their right to use arrangements that support Self-Determination and document the Enrollee's decisions regarding these arrangements;

ii. Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination including the authority to control an individual budget (with the assistance of a fiscal intermediary) and the right to employ (hire, manage, and when necessary terminate) workers and contracts with providers;

iii. Make personnel available to help inform, navigate, connect, and refer the Enrollees who are using arrangements that support Self-Determination.

M. Notification of Self- Determination Options.

a. HCBS Waiver Enrollees must be informed of the option to self-direct their own services when applicable. The Care Coordinator must ensure Enrollees are informed of the option to self-direct their services when their ICPs are created or updated.

b. Explanations of the Self-Determination Option must:

i. Make clear that self-direction of services is voluntary, and that Enrollees can choose the extent to which they would like to self-direct their services;

ii. Provide the options to select self-directed supports or services;

iii. Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in self-direction.

iv. Contractor must report to MDHHS on a regular basis in a format determined by MDHHS, the number of enrollees utilizing self-direction; and the types of services being provided in self-directed arrangements.

6.12 Continuity of Care.

A. Service Transitions.

a. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth in Exhibits 1 and 2 below.

b. For Enrollees receiving services from the Habilitation Supports Waiver (HSW)and/or through the PIHP under the Michigan 1115 Behavioral Health Demonstration, the following continuity of care requirements apply to Contractor services.

Exhibit 1 - Contractor Transition Requirements for HSW and Enrollees receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration.

Provider Type	**Contractor Transition Requirement for HSW and Enrollees Receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration**
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for one hundred and eighty (180) calendar days. (Contractor must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred and eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care

Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Home Health	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for one hundred eighty (180) calendar days. The ICP must be reviewed and updated and providers secured within one hundred eighty (180) calendar days of Enrollment. If Contractor fails to meet this requirement the continuity of care period must remain in place until the requirement is met. Contractor can increase or reduce the amount of services during the continuity of care period if a reassessment is conducted utilizing the Personal Care Assessment and the ICP is reviewed and updated with enrollee approval.

Exhibit 2 - Contractor Transition Requirements for all Other Enrollees.

Transition Requirements	**Contractor Transition Requirements for All Other Enrollees**
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for ninety (90) calendar days. (Contractor must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days

Vision and Dental	Must honor PAs when an item has not been delivered
Home Health	Maintain current level of service and same provider at the time of Enrollment for ninety (90) calendar days
Medicaid Nursing Facility Services	Enrollee may remain at the facility through contract with Contractor or via single case agreements or on an out-of-network basis until the Enrollee chooses to relocate.
Waiver Services	Maintain current providers and level of services at the time of Enrollment for ninety (90) calendar days unless changed during the Person- Centered Planning Process for services provided by the HIDE D-SNP HBCS waiver.
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for ninety (90) calendar days. The ICP must be reviewed and updated and providers secured within ninety (90) calendar days of Enrollment. If Contractor fails to meet this requirement the continuity of care period must remain in place until the requirement is met. Contractor can increase or reduce the amount of services during the continuity of care period if a reassessment is conducted utilizing the Personal Care Assessment and the ICP is reviewed and updated with enrollee approval.

c. Enrollees in the Habilitation Supports Waiver will continue to receive waiver services through the PIHP. Waiver services will not change due to Enrollment in Contractor.

d. Contractor will provide the State Plan Personal Care benefit to Enrollees.

e. For all other Enrollees, the following continuity of care requirements apply to Contractor services:

f. During the transition period referenced in Exhibits 1 and 2, changes from the existing provider or reductions in the amount, scope and duration of services can only occur in the following circumstances:

   i. The Enrollee requests a change;

   ii. The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or

iii. Contractor, CMS, or MDHHS identifies provider performance issues that affect an Enrollee's health and welfare.

iv. As described in Exhibits 1 and 2.

g. For individuals enrolled with the HIDE SNP, that disenroll then return to the HIDE SNP, the HIDE SNP must allow a continuity of care period for personal care services.

i. The HIDE SNP must continue services based on the personal care services received at the time of the disenrollment.

ii. If the beneficiary did not receive personal care services external to the HIDE SNP during the period of HIDE SNP disenrollment, the beneficiary can be out of the HIDE SNP for 3 months OR as long as the personal care assessment has not expired, whichever is longest, to receive continuity of care.

iii. If personal care services were received external to the HIDE SNP during the period of HIDE SNP disenrollment, the HIDE SNP must honor the most recent amount, scope and duration of the services received during the disenrollment unless one of the criteria referenced in e.i-iv in this section are met.

iv. The continuity of care period is as follows:

(a) 180 days for individuals receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration or Habilitation Supports Waiver.

(b) 90 days for all other individuals.

v. Any reduction, suspension, denial or termination of previously authorized services must trigger the required Notice under 42 C.F.R. §§ 438.404, and 422.568 which articulates the Enrollee's right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the plan renders an Adverse Benefit Determination (either in whole or in part) on the Appeal.

B. Drug Transitions.

a. Part D transition rules and rights will continue as provided for in current law and regulation.

b. Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on Contractor's formulary but require prior authorization or step therapy under Contractor's UM rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

c. All non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of Enrollment will be honored for ninety (90) calendar days after Enrollment and will not be terminated at the end of ninety (90) calendar days without advance Notice to the Enrollee and transition to other services, if needed.

C. Provider Transitions.

a. During the transition period outlined in Exhibits 1 and 2, Contractor will allow Enrollees access to any provider seen by the Enrollee within the previous twelve (12) months, as indicated in CareConnect360, or reported by the Enrollee or provider, prior to transition, even if the provider is not in Contractor's network.

b. During the transition period, Contractor will advise Enrollees and providers if and when they have received care that would not otherwise be covered in-network.

c. On an ongoing basis, and as appropriate, Contractor must contact providers who provide services to Contractor Enrollees but who are not members of Contractor's network to provide information on becoming in-network providers.

d. Out-of-network Nursing Facilities must be offered Single Case Agreements to continue to care for the Enrollee if the Nursing Facility does not participate in Contractor's network and the Enrollee:

i. Resides in the Nursing Facility at the time of Enrollment;

ii. Has a family member or spouse that resides in the Nursing Facility; or

iii. Requires Nursing Facility care and resides in a retirement community that includes a Nursing Facility.

D. Transferring Care/Service Plans and Liabilities.

a. Contractor must be able to accept and honor established care/service plans provided on paper or electronically transferred from FFS, PACE, another Contractor or other plan when Enrollees transition with care/service plans in place, until the ICP is developed.

b. Contractor must ensure timely transfer of an ICP, HRA, and any other data to support continuity of care to another Contractor, FFS, PACE, or other plan when an Enrollee is disenrolling from Contractor.

c. If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, Contractor must arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a Treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. Contractor must maintain documentation of such transfer of responsibility of medical care or treatment.

d. For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a per diem basis, Contractor will be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment.

e. For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a DRG basis, Contractor will be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective date of disenrollment.

E. Transitions Prior to the End of the Transition Period.

a. Contractor may choose to transition the Enrollee to a network specialist or LTSS provider before the end of the transition period only if all the following criteria are met:

i. The Health Risk Assessment and Additional Assessments if applicable, are complete;

ii. The ICP is developed with Enrollee input and includes a transition plan to be updated and agreed to with the new provider, as necessary; and

iii. The Enrollee agrees to the transition and ICP prior to the expiration of the transition period.

7. Quality Assessment and Performance Improvement Program

7.1 General Quality Requirements.

A. Contractor must deliver quality care that enables Enrollees to avoid preventable disease, manage chronic illnesses and disabilities, and maintain or improve health and quality of life, and that addresses SDoH and HRSN to reduce Health Disparities experienced by different subpopulations of Enrollees and ultimately achieve Health Equity. Quality care refers to the following criteria:

a. Quality of physical health care, including primary and specialty care;

b. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

c. Quality of LTSS focused on maximizing independence, rebalancing, community integration, and Self-Determination;

d. Adequate access to and availability of primary care, behavioral health care, pharmacy, dental, vision, hearing, transportation, specialty health care, and LTSS providers and services; and all other services covered under Medicaid State Plan as outlined in Medicaid Provider Manual.

e. Equitable distribution of care and services to Contractor's entire population, including members of racial/ethnic minorities, those whose primary language is not English, rural area residents, and those with disabilities;

f. Continuity and coordination of care across all care and services settings, including transitions in care;

g. Seamless Enrollee and caregiver experience with and access to high quality, person-centered, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum;

h. Best practices with regards to disease and risk screening, assessment and prevention;

i. Sufficient and capable organizational structure and staffing;

j. Environment and actions that promote quality of life, health, and well-being for Enrollees; and

k. Effective UM that generates value for the resources spent by Enrollees, families, and governments.

B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor's service delivery system, including all aspects delegated to First Tier, Downstream or Related Entities, through ongoing analysis, evaluation and systematic enhancements based on:

a. Quantitative and qualitative data collection and data-driven decision-making;

b. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

c. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities; and

d. Issues identified by Contractor, MDHHS and/or CMS.

C. If Contractor delegates any of the quality improvement activities to a contracted First Tier, Downstream or Related Entity, Contractor must ensure that the First Tier, Downstream or Related Entity comply with the requirements outlined in this section.

D. Contractor must ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health services, pharmacy, dental, vision, hearing, transportation, specialty health care, LTSS, and all other services covered under Medicaid State Plan as outlined in Medicaid Provider Manual.

E. Contractor must ensure that Contractor collects and meaningfully uses demographic and geographic data (e.g., race, ethnicity, language, disability, sexual orientation, gender identity) to identify

and address disparities. Contractor must report to MDHHS demographic and geographic data collected upon request.

7.2 QAPI Program Structure

A. Contractor must structure its QAPI program to meet all State and Federal requirements and align with its Model of Care, as approved by MDHHS, CMS, and NCQA. Required measures, reports, surveys, and QAPI initiatives must be specific for HIDE SNP and must be reported for the HIDE SNP population only.

B. Contractor must maintain a well-defined QAPI organizational and program structure that supports the application of the principles of CQI to all aspects of Contractor's service delivery system.

C. The QAPI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. Contractor's QAPI organizational and program structure must comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement QAPI Functions and Responsibilities.

D. Contractor must:

a. Establish a set of QAPI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QAPI initiatives and for the completion of QAPI initiatives in a competent and timely manner;

b. Ensure that such QAPI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of Contractor's service delivery system;

c. Seek, document, and utilize the input of providers and medical professionals representing the composition of Contractor's Provider Network in developing functions and activities;

d. Establish internal processes to ensure that the QAPI activities for primary care, behavioral health care, pharmacy, dental, vision, hearing, transportation, specialty health care, LTSS, and all other services covered under Medicaid State Plan as outlined in Medicaid Provider Manual, reflect utilization across the network

and include all of the activities in this Contract and, in addition, the following elements:

i. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), the Health Outcomes Survey (HOS), and any other quality measures required to be collected and reported by MDHHS and CMS, as well as their results, in designing QAPI activities;

ii. A process to incorporate SDoH and HRSN into the process of collecting and analyzing data to support reducing Health Disparities and addressing health inequities;

iii. A process for identifying and addressing Health Disparities in access to healthcare and health outcomes experienced by different populations of Enrollees, including Enrollees receiving LTSS. Contractor must stratify measures by race, ethnicity and other demographic factors;

iv. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process must include the sampling method used which must be proportionate to utilization by service type, including LTSS. Contractor must submit its process for medical record reviews and the results of its medical record reviews to MDHHS annually;

v. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with Contractor's plan, consistent with the requirements of this Contract and any other CMS or MDHHS requirements. Contractor must submit the results of the survey to MDHHS annually;

vi. A process to address and minimize administrative burden for Network Providers, especially LTSS providers, in the areas of payment, prior authorization, and coordination of care;

vii. A process to measure clinical reviewer consistency in applying clinical criteria to UM activities using inter-rater reliability measures;

viii. A process to detect both underutilization and overutilization of services

ix. A process for including Enrollees and their families or other representatives in Quality-related activities, as evidenced by participation in the Enrollee Advisory Committee; and

x. A process to assess the quality and appropriateness of care furnished to Enrollees using LTSS, including an assessment of care between settings and a comparison of services and supports received with those in the Enrollee's Integrated Care Plan.

xi. A process for prevention, detection and remediation of critical incidents (consistent with assuring beneficiary health and welfare pursuant to 42 C.F.R §§ 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the State for HCBS waiver programs under 42 C.F.R. § 441.302(h).

xii. A process to develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program.

xiii. Have in place a written description of the QAPI Program that delineates the structure, goals, and objectives of Contractor's QAPI initiatives. Such description must accomplish the following:

(a) Address all aspects of health care, including specific references to behavioral health care and LTSS, with respect to monitoring and improvement efforts, and integration with physical health care;

(b) Address the roles of the designated physician(s), behavioral health clinician(s) and LTSS providers with respect to the QAPI program;

(c) Identify the resources dedicated to the QAPI program including staff or data sources and analytic programs or IT systems; and

(d) Include organization-wide policies and procedures that document processes through which Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care as applicable to the population served and services provided by Contractor. Such processes must include, but not be limited to, Appeals and Grievances and UM.

e. Submit to MDHHS an annual QAPI Work Plan that must include the following components or other components as directed by MDHHS.

i. Planned clinical and non-clinical initiatives, including targeted interventions designed to reduce health disparities and address health inequities.

ii. Objectives for planned clinical and non-clinical initiatives.

iii. Short- and long-term time frames within which each clinical and non-clinical initiative's objectives are to be achieved.

iv. The individual(s) responsible for each clinical and non-clinical initiative.

v. Any barriers identified by Contractor, MDHHS, Enrollees, and providers, and how those barriers are tracked and resolved over time.

vi. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually.

vii. Process for correcting deficiencies.

viii. Incorporate any performance improvement objectives, established as a result of a performance improvement project or routine monitoring, into the written plan for its QAPI program.

ix. Incorporate initiatives aimed at meeting the goals and objectives outlined in the state's Comprehensive Quality Strategy.

x. Develop a process to evaluate the impact and effectiveness of QAPI program and submit the results to MDHHS at least

annually. The evaluation of QAPI program must include but not be limited to:

(a) Evaluation of Contractor's performance on all quality measures on which it is required to report as outlined in this Contract.

(b) Evaluation of the outcomes and trended results of each of Contractor's performance improvement projects.

(c) Results of any efforts made by Contractor's to support community integration for Enrollees using LTSS.

(d) Evaluation of accomplishments, compliance and/or deficiencies in meeting the previous year's annual QAPI Work Plan's goals and objectives.

f. Contractor must maintain a HIDE SNP Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results, and activities, and recommending changes on an ongoing basis. HIDE SNP QIC must focus on areas relevant to HIDE SNP model of care and populations served. The QIC must include the following individuals:

i. At least one designated physician who must be a Medical Director or Associate Medical Director, at least one designated behavioral health clinician, and one clinical professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QAPI program, each with qualifications as deemed appropriate by MDHHS;

ii. A qualified individual to serve as the full-time Quality Improvement and Utilization Director who possesses the training and education necessary to meet the requirements for quality improvement and utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be a Michigan licensed physician, Michigan licensed registered nurse, certified professional in health care quality, other licensed clinician as approved by MDHHS, or other professional possessing appropriate credentials as approved by MDHHS. This individual will be responsible for the following:

iii. Overseeing all QAPI activities related to Enrollees, ensuring compliance with all such activities, and maintaining

accountability for the execution of and performance in all such activities;

iv. Maintaining an active role in Contractor's overall QAPI structure; and

v. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QAPI activities including, but not limited to, the following:

(a) Physical, dental, and behavioral health care;

(b) Pharmacy management;

(c) Care coordination;

(d) Utilization management;

(e) LTSS;

(f) Financial;

(g) Statistical and analytical;

(h) Information systems;

(i) Marketing and publications;

(j) Enrollment; and

(k) Operations management.

7.3 Health Equity.

A. Contractor must collaborate with Contractor's Care Coordination team to ensure health equity is advanced in the context of Contractor's population health and care coordination initiatives for HIDE SNP program;

B. Contractor must actively participate in, or assigning staff to actively participate in, MDHHS' Quality and Care Coordination Workgroup and other meetings or activities that may be facilitated by MDHHS, or its designee, that may be attended by representatives of MDHHS, a MDHHS contractor, Contractor, and other entities, as appropriate; and

C. Contractor must serve as liaison to, and maintain regular communication with, Michigan QAPI representatives. Responsibilities will include, but are not limited to, promptly

responding to requests for information and/or data relevant to all QAPI activities.

7.4 Health Information System

A. Contractor must maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QAPI Program, including all aspects of Contractor's Model of Care. Contractor's health information system must have the capabilities to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a) and (b).

7.5 QAPI Activities.

A. Contractor must engage in performance measurement and quality improvement projects designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes, and Enrollee experience and reduction of Health Disparities and health inequities.

B. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

C. Contribute, as directed by MDHHS, to processes culminating in the development of annual or other reports by MDHHS regarding the individual and aggregate performance of HIDE SNP program Contractors.

D. At MDHHS' direction, Contractor must fully and completely participate in quality initiatives, including, but not limited to, the Comprehensive Quality Strategy (CQS), Health Equity Projects, and Medical and Oral Health Coordination and Integration initiatives. Contractor will be responsible to report all required information to MDHHS within specified timelines.

7.6 Performance Measurement.

A. In addition to meeting all CMS requirements on performance measurement for HIDE SNP plans, Contractor must perform and report the quality and utilization measures identified by CMS and MDHHS for HIDE SNP program and as articulated in this Contract and as outlined in Appendix F.

B. Contractor must adhere to reporting specifications provided annually in the Michigan HIDE SNP Reporting Requirements Technical Specifications and annual Reporting Requirements for HEDIS, HOS, and CAHPS Measures memorandum;

C. Contribute, as directed by MDHHS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by MDHHS and rectifying those inadequacies, as directed by MDHHS and

D. Contractor must submit HEDIS, HOS and CAHPS data and calculated rates directly to MDHHS at the time of submission to CMS.

E. Contractor must submit all applicable Part C and Part D reporting sections as articulated in the Medicare Part C Reporting Requirements and the Medicare Part D Reporting Requirements to MDHHS upon request.

F. Contractor will contribute to and support, as requested by MDHHS, the collection and reporting of state-level data such as for the Core Set of Adult Health Care Quality Measures for Medicaid, HCBS 1915 (c) waiver assurances, MCPAR, and other CMS and MDHHS-required measures.

G. Contractor must monitor other performance measures not specifically stated in the Contract that are required by CMS or MDHHS.

H. For all standard national performance measures, Contractor must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and MDHHS. MDHHS (or its designee) will perform an independent validation of at least a sample of Contractor's findings.

I. Contractor must document and implement an internal process to validate all performance measure data for completeness and accuracy which must include a review of the performance measure data before submission to MDHHS. For non-standard or state-specific measures, Contractor must participate in measure validation activities prescribed by the State, if any.

J. MDHHS reserves the right to review and validate all performance measure data for completeness and accuracy. Contractor must fully cooperate with all MDHHS efforts to monitor Contractor's

compliance with the requirements of performance measure data validation and comply with all MDHHS requests in a timely manner as directed by MDHHS. Contractor must cooperate and comply with any audit arranged for by MDHHS to determine accuracy, truthfulness, and completeness of submitted performance measure data.

K. Contractor's failure to consistently submit complete and accurate performance measure data and participate in MDHHS performance measure data quality activities and reviews in accordance with MDHHS standards may impact scoring for Quality Withholds as referenced in Appendix G and subject Contractor to MDHHS contract remedies including but not limited to monetary Sanctions and other Sanctions, such as corrective action.

L. Contractor must contribute to MDHHS processes culminating in the publication of any additional technical or other reports by MDHHS related to the noted measures.

7.7 Enrollee Experience Surveys.

A. Contractor must conduct Enrollee experience survey activities, as directed by MDHHS and/or CMS, and in alignment with Contractor's Model of Care, as follows:

a. Conduct, as directed by MDHHS and CMS, an annual CAHPS survey and add supplemental questions as determined by MDHHS using an approved CAHPS vendor. Contractor must directly contract with an NCQA-certified CAHPS vendor and submit the data according to the specifications identified by CMS and established by NCQA. Annually, Contractor must provide NCQA summary and Enrollee level data to MDHHS. Contractor must provide an electronic copy of the final survey analysis report to MDHHS. A hard copy must be provided to MDHHS upon request;

b. Contribute, as directed by MDHHS, to the administration of consumer experience surveys for Enrollees utilizing LTSS, including but not limited to the CAHPS Home and Community Based Services Survey;

c. Conduct, as directed by MDHHS, a quality of life survey, adapted for general populations. This survey may be self-administered or

administered by a trained interviewer and results must be submitted to MDHHS upon request;

d. Contractor must utilize Enrollee experience surveys results in designing QAPI initiatives and in its broader CQI efforts.

7.8 Provider Experience Surveys.

A. Contractor must conduct an annual Provider experience survey, as directed by MDHHS, which addresses, at a minimum, the following topics:

a. Overall satisfaction with Contractor.

b. Ease of billing/promptness of payment.

c. Prior authorization process.

d. Referral process.

e. Satisfaction with Contractor's Provider Relations Department.

f. Satisfaction with Contractor's Enrollee Services.

g. Involvement in Contractor's Care Coordination processes, including participation in the ICT and collaboration in developing and implementing ICPs.

h. Complaint resolution.

B. If requested by MDHHS, Contractor will use a standard survey template provided by MDHHS to facilitate comparability across the integrated program.

C. Contractor will ensure that results of the Provider experience survey are reported to MDHHS specifically for the integrated program and not aggregated with other populations and programs.

D. Contractor's Provider experience survey activities must include all types of Network Providers, including providers of behavioral health and LTSS. Contractor may choose to administer a separate targeted survey specifically for LTSS providers, or to include all LTSS provider types within its broader survey.

7.9 Performance Improvement Project (PIP) Requirements.

A. Contractor must conduct quality improvement projects that focus on clinical and non-clinical areas including any performance

improvement projects required by MDHHS and included in Contractor's Model of Care.

B. Contractor must implement and adhere to all processes relating to the PIP requirements, as directed by MDHHS, as follows:

   a. Collaborate with MDHHS and stakeholders to determine priority areas for performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the HIDE SNP population, as defined by MDHHS.

   b. In accordance with 42 C.F.R. §438.330 (d), collect information and data in accordance with PIP requirement specifications for its Enrollees using the annual format and submission guidelines specified by MDHHS and EQRO contractor.

   c. Implement the PIP requirements, in a culturally competent manner, to achieve objectives as specified by MDHHS.

   d. The PIP must be relevant to and target Contractor's HIDE SNP population.

   e. Conduct an annual evaluation of the effectiveness of the intervention included in its PIP. Plan and initiate processes to sustain achievements and continue improvements.

7.10 External Quality Review (EQR) Activities.

A. Contractor must take all steps necessary to support the External Quality Review Organization (EQRO) contracted by MDHHS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358. Contractor must participate fully and completely with all EQR-related activities as specified by MDHHS and/or federal regulations.

B. Contractor must address the findings of the external review through its QAPI program.

C. Contractor must develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor 's QAPI program.

D. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QAPI program.

E. MDHHS may also require separate submission of an improvement plan specific to the findings of the EQRO.

F. EQR activities will include, but are not limited to the following:

   a. Annual validation of performance measures reported to MDHHS, as directed or calculated by MDHHS.

   b. Annual validation of provider Network Adequacy including conducting annual Secret Shopper Surveys.

   c. Annual validation of encounter data reported by Contractor to MDHHS.

   d. Annual validation of performance improvement projects required by MDHHS.

G. At least once every three (3) years, review compliance with standards set forth in 42 CFR §438 subpart D, the disenrollment requirements and limitations described in 42 CFR §438.56, the enrollee rights requirements described in 42 CFR §438.100, the emergency and post-stabilization services requirements described in 42 CFR §438.114, and the quality assessment and performance improvement requirements described in 42 CFR §438.330.

H. Contractor must take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

   a. Designating a qualified individual to serve as project director for each EQR activity who must, at a minimum perform the following activities:

      i. Oversee and be accountable for compliance with all aspects of the EQR activity.

      ii. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, MDHHS staff in a timely manner.

      iii. Serve as the liaison to the EQRO, QIO, MDHHS and answer questions or coordinate responses to questions from the EQRO, QIO, and MDHHS in a timely manner.

      iv. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or MDHHS.

b. Maintaining data and other documentation necessary for completion of EQR activities specified above. Contractor must maintain such documentation for a minimum of ten (10) years.

c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or MDHHS.

d. Participating in Contractor-specific and cross- Contractor meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and MDHHS.

e. Implementing actions, as directed by MDHHS , to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, MDHHS, in subsequent years.

f. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by MDHHS.

7.11 Accreditation.

A. Contractor must have a Medicaid Health Plan Accreditation inclusive of the Medicaid Module by the National Committee for Quality Assurance (NCQA) with the LTSS Distinction.

B. When accreditation standards conflict with the standards set forth in the Agreement, the Agreement prevails, unless the accreditation standard is more stringent.

C. If Contractor is accredited as of the start date of the Agreement, Contractor must maintain accreditation throughout the term of this agreement.

a. If Contractor is not accredited as of the start date of this Contract, Contractor must obtain their Medicaid Health Plan Accreditation inclusive of the Medicaid Module and the LTSS Distinction no later than the end of the second full calendar year of operation and must maintain accreditation for the term of this Contract.

D. In addition, Contractor must hold and maintain NCQA Health Equity Accreditation in the State of Michigan.

a. If Contractor is not accredited as of the date of this Contract, Contractor must obtain Health Equity Accreditation no later than

the end of the second full calendar year of operations and must maintain accreditation for the term of this Contract.

E. Contractor must inform MDHHS if it is nationally accredited or if it has sought and been denied such accreditation and authorize the accrediting entity to submit to MDHHS, at MDHHS's direction, copy of its most recent accreditation review including the expiration date, the recommended action or improvements, corrective action plans, and summaries of findings, if any, in addition to the results of other quality related external audits, if any.

   a. Upon accreditation from NCQA, Contractor must report to MDHHS any deficiencies noted by NCQA for any current accreditation or distinction within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

7.12 Utilization Management

A. Contractor must utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.

B. The UM activities of Contractor must be integrated with Contractor's QAPI program.

C. The QI activities for the UM program must include, at a minimum, the following:

   a. Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes and comply with all relevant federal and State laws and regulations.

   b. A formal Utilization Review Committee directed by Contractor's Medical Director to oversee the utilization review process.

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

   d. An annual review and reporting of utilization review activities, and outcomes and interventions from the review.

   e. A process to detect both underutilization and overutilization of services.

D. Contractor must establish and use a written prior approval policy and procedure for UM purposes.

   a. Contractor may not use such policies and procedures to avoid providing Medically Necessary Services within the coverage established under the Contract.

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

   c. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

E. Contractor must ensure that compensation to the individuals or First Tier, Downstream, or Related Entity that conduct UM activities is not structured so as to provide incentives for the individual or First Tier, Downstream, or Related Entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

7.13 Clinical Practice Guidelines.

A. Contractor must adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that include the following:

   a. Are based on current, valid, and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of LTSS.

   b. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of services.

   c. Do not contradict existing Michigan-promulgated statute and policies or requirements as published by the Departments of Community Health, Human Services, Licensing and Regulatory Authority, Insurance and Financial Services, or other State agencies.

d. Prior to adoption, have been reviewed by Contractor's Medical Director, as well as other practitioners and Network Providers, as appropriate.

e. Are reviewed and updated, as appropriate, or at least every two (2) years.

B. Guidelines must be reviewed and revised, as appropriate, based on changes in national guidelines, changes in valid and reliable clinical evidence, or consensus of health care professionals and providers.

C. For guidelines that have been in effect 2 years or longer, Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly.

D. Contractor must disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Potential Enrollees.

E. Contractor must make the clinical and practice guidelines available via Contractor's web site.

F. Contractor must notify providers of the availability and location of the guidelines, and must notify providers whenever changes are made.

G. Contractor must submit these guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards.

H. Contractor must establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services.

I. Contractor must submit to MDHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by Contractor, upon request.

7.14 QAPI Workgroups.

A. As directed by MDHHS, Contractor must actively participate in MDHHS' Quality & Care Coordination Workgroup and any other quality management workgroups or activities, attended by representatives of MDHHS, Contractors, and other entities, as

appropriate, and that are designed to support QAPI activities and to provide a forum for discussing relevant issues.

B. Participation may involve contributing to QAPI initiatives identified and/or developed collaboratively by the workgroup.

7.15 MDHHS Directed Medicaid Quality Withhold/Performance Incentive Program.

A. In support of MDHHS' commitment to quality improvement, innovation, and operational excellence of Medicaid services, MDHHS will withhold a percentage of the Medicaid Capitation Payment from Contractor and make the return of these withheld funds contingent upon Contractor meeting certain quality and performance metrics.

B. Beginning calendar year 2027, MDHHS will withhold 2.00% of the Capitation Payment. MDHHS reserves the right to revise the withhold percentage ahead of each fiscal period.

C. MDHHS will require that Contractor meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract.

D. These withhold measures are listed in Appendix G. Additional details are outlined in HIDE SNP Quality Withhold Technical Notes.

E. In order to receive any withhold payments, Contractor must comply with all MDHHS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

7.16 Enrollee Incentives.

A. Contractor may implement Enrollee incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings, PCP visits, and wellness initiatives). Contractor must do the following:

a. Take measures to monitor the effectiveness of such Enrollee incentives, and revise incentives as appropriate, with consideration of Enrollee feedback; and

b. Submit to MDHHS, annually and at the direction of MDHHS, information relating to planned and implemented Enrollee incentives, including evaluation of effectiveness of the incentives. Contractor must assure that all such Enrollee

incentives comply with all applicable requirements, including 42 C.F.R § 422.134, as well as State and Federal laws.

B. MDHHS reserves the right to impose limitations or deny an incentive that seems inappropriate for health prevention and promotion behaviors.

7.17 Behavioral Health Services Outcomes.

A. Contractor must work with PIHPs and MDHHS to report on MDHHS-defined shared metrics that seek to measure the quality of care provided to Enrollees jointly served by Contractor and PIHPs, and in alignment with MDHHS-approved Coordinating Agreements.

B. Contractor must work collaboratively with PIHPs, PCPs, and MDHHS to develop and implement quality improvement projects involving shared metrics and incentives for performance.

C. Contractor must report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.

7.18 Dissemination of Quality Performance Information.

A. MDHHS reserves the right to publish Contractor-level and provider-level quality performance data and information, including but not limited to:

a. Quality Measure rates.

b. Contractor's performance related to the State's Comprehensive Quality Strategy goals.

c. NAV findings.

d. CAHPS surveys.

e. The status and impact of quality improvement initiatives and interventions.

f. Information regarding the status of Contractor PIPs and any Corrective Action Plans (CAPs).

8. Medicaid Cost Sharing and Coordination of Benefits.

8.1 Cost Sharing for Medicaid Services: Since the capitation rate paid to Contractor includes Medicaid payment of Medicare cost sharing Contractor will ensure the following.

A. For Medicaid services, Contractor will not charge cost sharing to Enrollees.

B. Contractor must waive Medicaid cost sharing.

C. Enrollee Contribution to Care Amounts:

a. The amount an enrollee must pay toward Medicaid Nursing Facility care is known as the PPA, and is calculated for every individual receiving Nursing Facility Care by the local MDHHS office, although not every eligible individual will have a PPA.

b. MDHHS will provide information to the HIDE SNP that identifies Enrollees who are required to pay a PPA and the amount of the obligation via 834 files.

c. Medicaid Component of MDHHS Capitation Payments to the HIDE SNP for Enrollees who are required to pay a PPA will be net of the monthly PPA.

d. It is the responsibility of the Nursing Facility provider to collect the PPA from Enrollees, and the HIDE SNP must reduce reimbursements to Nursing Facility providers equal to the PPA amount each month.

e. PPA may be prorated for stays less than a full month. Proration is based on the facility's Medicaid daily rate charged to the Enrollee per day until the PPA is exhausted.

8.2 Protecting Member from Liability for Payment.

A. In accordance with 42 CFR §438.106 and 42 CFR §447.15, Contractor must ensure that its Members are not held liable for payment for any services provided under this Contract other than Member patient pay liability towards Nursing Facility Care and Part D cost sharing.

B. Contractor must ensure that all in-network provider agreements include requirements whereby the Member must not be charged for any Medicaid covered service or Supplemental Service provided by Contractor.

C. This includes circumstances in which the provider fails to obtain necessary referrals or preauthorization or fails to perform other required administrative functions.

D. Contractor must ensure Provider Network compliance with all Member payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any provider within Contractor's Network that does not comply with such provisions.

E. Pursuant to Section 1932(b)(6), (42 USC § 1396u-2 (b)(6)), and in accordance with 42 CFR §438.106, Contractor and all of its providers and Subcontractors must not hold a Member liable for:

   a. Debts of Contractor in the event of Contractor's insolvency.

   b. Covered services provided to the Member for which Contractor has not received payment from MDHHS for the services; or, the provider, under contract or other arrangement with Contractor, fails to receive payment from MDHHS or Contractor.

   c. Payments in excess of the contracted amount.

   d. Payments to providers that furnish covered services under a contract or other arrangement with Contractor that are in excess of the amount that normally would be paid by the Member if the service had been received directly from Contractor.

   e. Coinsurance, copayments, deductibles, financial penalties, or any other amount other than any patient pay towards Nursing Facility Care.

F. As specified in Section 1128B(d)(1) of the Social Security Act (42 USC § 1320a-7b), as amended, Contractor and all of its Subcontractors are subject to criminal penalties if providers knowingly and willfully charge money or other consideration at a rate in excess of the rate established by MDHHS for any service provided to a Member under the State Plan or under this Contract. This provision remains in effect even if Contractor becomes insolvent until such time as Members are withdrawn from assignment to Contractor.

8.3 Cost Sharing Protections.

A. Except with regard to Part D cost sharing, Contractor will pay providers for Medicare-covered services the amount of cost sharing

for which Michigan Medicaid is liable based on the submission of the Medicare claim, without requiring submission of a second claim for cost sharing.

B. Contractor's system must provide for coordinating benefits for Enrollees that are also covered by Medicare.

C. Contractor must communicate fully integrated Medicare-Medicaid coverage to all members, providers, Contractor staff, and other stakeholders, including guarantee of complete member protection from financial liability – meaning all deductibles, premiums, coinsurance, copayments, and cost sharing of any kind, with exception for PPA and PEME.

   a. As a general rule, if a participating or non-participating Provider renders a covered service to a HIDE SNP Enrollee, the Provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third-party liability, is Contractor, not the Enrollee.

   b. Notwithstanding any provision in this Contract to the contrary, an Enrollee will not be responsible for the cost of care, except for PPA and PEME.

8.4 Coordination of Benefits.

A. Contractor must comply with all applicable federal statutes and regulations including Section 1902(a)(25) of the Social Security Act, 42 C.F.R. Part 433, Subpart D.

B. Contractor will be responsible for coordination of benefits for all Medicare- and Medicaid-covered services, including appropriate applicability of coverage limits and determinations according to federal and State Laws.

C. Contractor will be responsible for the identification and collection of all third-party sources available for payment of Medicaid Covered Services described in the Contract and rendered to Enrollees, including court-ordered medical support available from a third party.

D. All funds recovered by Contractor must be retained by Contractor and considered income.

E. Contractor is responsible for obtaining from Enrollees any third-party payment source to Contractor pursuant to notification of this

responsibility as outlined in the Enrollees' written Evidence of Coverage.

a. This includes but is not limited to the following types of resources: health insurance, casualty and torts settlements or claims, and worker's compensation benefits.

8.5 Third Party Liability Comprehensive Health Coverage.

A. Enrollees determined by Contractor or MDHHS as having comprehensive health coverage other than Medicare or Medicaid must be prospectively disenrolled from the HIDE SNP, effective the first day of the month following the month in which the coverage was verified.

B. Enrollees will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the HIDE SNP is responsible for coordinating all benefits covered under this Contract.

C. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), MDHHS is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the Enrollee was not identified for exclusion prior to Enrollment in the HIDE SNP, or where the Enrollee gained other coverage after enrolling in the HIDE SNP, Contractor must take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties must be retained by the HIDE SNP and identified monthly to MDHHS and CMS.

8.6 Communicating Enrollee Liability for Payment.

A. Neither Contractor nor any of its Subcontractors may collect any additional payment for Cost Sharing Obligations from an Enrollee other than what is allowed by federal law.

B. For Enrollees in nursing facilities, the patient-pay amount will be communicated to the Enrollee regarding the amount required to pay toward the cost of care while in the nursing facility.

9. Enrollee Access to Services.

9.1 General Provisions

A. Contractor must authorize, arrange, coordinate and ensure the provision of all Medically Necessary Covered Services for Enrollees, as specified in Section IV in accordance with the requirements of this contract. Services must be available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

B. Contractor must have a mechanism in place to allow Enrollees to directly access specialists as appropriate for the Enrollee's condition and identified needs.

a. All Non-urgent Symptomatic Care must be available to Enrollees within seven (7) business days.

b. Network providers must offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

C. Contractor must reasonably accommodate persons and must ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities.

D. Contractor and its network providers must comply with the American with Disabilities Act (ADA) as outlined in Section 9.9 of this Contract.

E. Contractor must have written policies and procedures to assure compliance including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from Contractor by:

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

b. Providing interpreters or translators for Enrollees who are Deaf or hard of hearing and those who do not speak English.

c. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication,

including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

i. Providing large print (at least 16-point font) versions of all written materials to individuals who are blind or with limited vision.

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

iii. Reading Notices and other written materials to individuals upon request.

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

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

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

vii. Providing individualized forms of assistance.

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

ix. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

x. Contractor must identify to MDHHS the individual in its organization who is responsible for ADA compliance related to this contract and his/her job title. Contractor must also establish, execute, and annually update a work plan to achieve and maintain ADA compliance.

F. Contractor must give written notice of termination of a provider irrespective of whether the termination was for cause or without cause. See 42 CFR §§422.111(e) and 438.10(f). Contractor must make a good faith effort to give notice of a for-cause termination of

a provider within the timeframes required. For all terminations, Contractor must meet the following requirements:

a. For contract terminations that involve a PCP or behavioral health provider at least forty-five (45) calendar days before the termination effective date, provide written notice and make one attempt at telephonic notice to Enrollees (unless Enrollees have opted out of calls) who are currently assigned to that PCP and to Enrollees who have been patients of the PCP or behavioral health provider within the past three (3) years.

b. For contract terminations that involve specialty types other than primary care or behavioral health at least thirty (30) calendar days before the termination effective date, provide written notice to all Enrollees who are assigned to, currently receiving care from, or have received care within the past three (3) months from a provider or facility being terminated.

c. When the Food and Drug Administration (FDA) determines a drug to be unsafe, Contractor must follow Chapter 6 of the Medicare Prescription Drug Benefit Manual for removal of the drug from its formulary.

9.2 Services Not Subject to Prior Approval.

A. Emergency Medical Conditions: Contractor will assure coverage of Emergency Medical Conditions and Urgent Care Services. Contractor must not require prior approval for the following services:

a. Any services for Emergency Medical Conditions as defined in 42C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care).

b. Urgent Care sought outside of the Service Area.

c. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible.

d. Family planning services.

e. Out-of-area renal dialysis services.

B. Communicable Disease Services; Contractor must cover or pay applicable Medicare cost sharing for Enrollees to receive treatment

services for communicable diseases from local health departments without prior authorization: including HIV/AIDS, Sexually Transmitted Infections (STI), tuberculosis, and vaccine-preventable communicable diseases.

C. Non-Emergent Family Planning Services: Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization.

9.3 Authorization of Services

A. Contractor must authorize services as in accordance with 42 C.F.R. § 438.210.

a. For the processing of requests for initial and continuing authorizations of Covered Services, Contractor and any First Tier, Downstream, or Related Entities must:

i. Have in place and follow written policies and procedures.

ii. Have in place procedures to allow Enrollees to initiate requests for provision of services.

iii. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions.

iv. Consult with the requesting provider when appropriate.

B. Contractor must ensure that a Contractor representative and a behavioral health provider are available twenty-four (24) hours a day for timely authorization of Medically Necessary Services, including, if necessary, the transfer of the Enrollee who presented to an emergency department with an Emergency Medical Condition that has been Stabilized. If Contractor waives or otherwise does not require prior authorization of such services, 24 hour coverage for authorization is not required.

C. Contractor's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and substance use disorder services.

a. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's

medical condition, performing the procedure, or providing the treatment.

b. Behavioral health services denials must be rendered by board-certified or board- eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which must be rendered by a qualified psychologist.

D. Contractor must assure that all behavioral health authorization and UM activities are in compliance with 42 U.S.C. § 1396u-2(b)(8).

E. Contractor must comply with the requirements for demonstrating parity for treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

F. Contractor must notify the requesting provider, either orally or in writing, and give the Enrollee a Coverage Determination Letter (CDL), of any decision by Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Notice must meet the requirements of 42 C.F.R. § 438.404 and must:

a. Be produced in a manner, format, and language that can be easily understood.

b. Be made available in Prevalent Languages, upon request.

c. Include information, in the most commonly used languages about how to request translation services and Alternative Formats.

G. Contractor must make authorization decisions in the following timeframes and provide Notice that meet the timing requirements set forth in 42 C.F.R. §§ 438.404 and 438.210:

a. For standard authorization decisions, provide Notice as expeditiously as the Enrollee's health condition requires and no later than seven (7) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension will only be allowed if:

i. The Enrollee or the provider requests an extension.

ii. Contractor can show to the satisfaction of MDHHS that:

(a) The extension is in the Enrollee's interest, and

(b) There is a need for additional information, and

(c) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received, and

(d) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

b. For expedited service authorization decisions, where the provider indicates or Contractor determines that following the standard timeframe in Section 9.3 G could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, Contractor must make a decision and provide Notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension will only be allowed if:

i. The Enrollee or the provider requests an extension; or

ii. Contractor can justify (to MDHHS upon request) that:

(a) The extension is in the Enrollee's interest; and

(b) There is a need for additional information where:

A. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

B. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

H. In accordance with 42 C.F.R. §§ 438.3(i), 438.210, and 422.208, compensation to individuals or entities that conduct UM activities for Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

I. When a service authorization decision is not reached within the applicable timeframe for either standard or expedited requests, Contractor must give Notice on the date that the timeframe expires.

J. Contractor must report prior authorization data following each calendar year, excluding data on any and all drugs covered by the Contractor, by March 31 of each year in accordance with 42 CFR 438.210 (f). Contractor must make this data from the previous calendar year publicly accessible by posting them on its website.

K. Contractor must engage in preparation activities related to APIs, so that requirements of the Interoperability and Prior Authorization Final Rule (CMS-0057-F) are met.

9.4 Authorization of LTSS.

A. Contractor must develop an authorization process for the approval of Long Term Services and Supports (LTSS).

B. At a minimum, Contractor's authorization of LTSS must comply with MDHHS's FFS authorization criteria for those Covered Services. However, Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the IICSP determines that such authorization would provide sufficient value to the Enrollee's care.

C. Value will be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the most integrated and least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS.

D. The ICO will be responsible for payment for any PCS and HCBS waiver services authorized and provided to an Enrollee during a period of active Enrollment. If an Enrollee is retroactively disenrolled from the Contractor after a PCS and/or HCBS service has been authorized and delivered, the Contractor must pay for the service. Recoupment from providers for PCS and HCBS services authorized and delivered is prohibited.

9.5 Emergency and Post-stabilization Care and Coverage.

A. Contractor's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community.

B. Contractor must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(b) and (c) and 42 C.F.R. § 422.113(b) and (c).

C. Contractor must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a Contract with Contractor.

   a. For reimbursement of an out-of-network provider of Emergency and Post-Stabilization Care, the provider is required to accept as payment in full the amounts provider could collect for that service if the Enrollee were enrolled in original Medicare, or Medicaid FFS. However, Contractor is not required to reimburse the provider more than the provider's charge for that service.

   b. The original Medicare payment amounts for section 1861(u) providers do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies Contractor in writing that it is billing an amount less than such amount.

   c. Contractor must ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

D. Payment must be made within sixty (60) calendar days after the Claim has been submitted.

E. Contractor must:

   a. Have a process established to notify the PCP or ICT (or the designated covering physician) of an Emergency Condition within one (1) business day after Contractor is notified by the provider. If Contractor is not notified by the provider within ten (10) calendar days of the Enrollee's presentation for Emergency Services, Contractor may not refuse to cover Emergency Services.

   b. Have a process to notify the PCP or ICT of required Urgent Care within twenty-four (24) hours of Contractor being notified.

   c. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee EHR no more

than twenty-four (24) hours after the PCP or ICT is notified, and a full report of the services provided within two (2) business days.

F. Contractor must not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R § 438.114 and 42 C.F.R § 422.113.

G. Contractor must not deny payment for treatment of an Emergency Medical Condition if a representative of Contractor instructed the Enrollee to seek Emergency Services.

H. Contractor may not deny payment for treatment obtained when a Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R § 438.114(a) and 42 C.F.R § 422.113(b) of the definition of Emergency Medical Condition.

I. Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

J. Contractor must require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

   a. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

   b. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge. That determination is binding on Contractor if:

      i. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

      ii. Is a Covered Service under the Contract.

K. Contractor must cover and pay for Post-Stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

L. Contractor must cover Post-Stabilization Care Services provided by provider in any of the following situations:

   a. Contractor authorized such services.

b. Such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Care Services; or

c. Contractor does not respond to a request to authorize further Post-Stabilization Care Services within one (1) hour, Contractor could not be contacted, or Contractor and the Treating Provider cannot reach an agreement concerning the Enrollee's care and a provider is unavailable for a consultation, in which case the Treating Provider must be permitted to continue the care of the Enrollee until a provider is reached and either concurs with the Treating Provider's plan of care or assumes responsibility for the Enrollee's care.

9.6 Emergency Medical Treatment and Labor Act (EMTALA).

A. Contractor and providers must comply with EMTALA, which, in part, requires:

a. Qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R.§ 489.24(b); and,

b. As applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

B. Contractor's contracts with its providers must clearly state the provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

9.7 Nurse Help Line.

A. Twenty-Four (24) Hour Coverage.

a. Contractor must provide a twenty-four (24) hour, seven (7) days toll-free system with access to a registered nurse who:

i. Has immediate access to the Enrollee Medical Record.

ii. Is able to respond to Enrollee questions about health or medical concerns.

iii. Has the experience and knowledge to provide clinical triage.

iv. Is able to provide options other than waiting until business hours or going to the emergency room, and

v. Is able to provide access to oral interpretation services available as needed, free-of-charge.

9.8 Linguistic Competency.

A. Contractor must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

B. Contractor must have the capacity to meet the needs of the linguistic groups in its Service Area.

a. The following must be available:

i. The provision of care, including twenty-four (24) hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

ii. Trained to translate in a medical setting,

iii. Fluent in English, and

iv. Fluent in the Enrollee's language.

v. Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS providers.

9.9 Access for Enrollees with Disabilities.

A. Contractor and its providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

B. Contractor and its providers can demonstrate compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility.

C. Physical and telephone access to services must be made available for individuals with disabilities and fully comply with the ADA.

D. Contractor must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from Contractor.

10. Enrollee Engagement

10.1 Enrollee Service Representatives (ESRs).

A. Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Potential Enrollees, consistent with the requirements of 42 C.F.R.§§ 422.111(h)(1) and 423.128(d)(1).

B. The ESRs must assist Enrollees, Enrollees' families, or caregivers (consistent with laws on confidentiality and privacy) in obtaining information and Covered Services from Contractor.

C. ESRs must be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees.

D. ESRs must maintain the availability of services, such as:

a. TTY services.

b. Computer-aided transcription services.

c. Telephone handset amplifiers.

d. Assistive listening systems.

e. Closed caption decoders.

f. Videotext displays.

g. Qualified interpreters including ASL.

h. Other services for enrollees who are deaf or hard of hearing.

E. ESRs must be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats.

F. ESRs must make oral interpretation services available free-of-charge to Enrollees with limited English proficiency and all non-English languages spoken by Enrollees, including ASL.

G. The ESR must inform callers that interpreter services are available free of charge.

H. ESRs must be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language,

including ASL, or through an alternative language device or telephone translation service.

I. ESRs must be knowledgeable about Michigan Medicaid, Medicare, and the terms of the Agreement, including the Covered Services listed in Appendix M.

J. ESRs must be knowledgeable about PIHP behavioral health services and enrollee service lines including the PIHP twenty-four (24) hour crisis line and transfer or refer callers appropriately.

K. ESRs must be available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances.

L. ESRs must have access to the Enrollee's EHR and an electronic Provider and Pharmacy Directory.

M. ESRs must demonstrate sensitivity to culture, including disability culture, the Independent Living Philosophy, and Person-Centered Planning.

N. ESRs must provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at or below sixth (6th) grade reading level, and individualized guidance from ESRs to ensure materials are understood.

O. ESRs must provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to Contractor.

P. ESRs must maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives.

Q. Contractor must ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

   a. The identity, locations, qualifications, and availability of providers.

   b. Enrollees' rights and responsibilities.

   c. The procedures available to an Enrollee and provider(s) to challenge or Appeal the failure of Contractor to provide a

Covered Service and to Appeal any Adverse Benefit Determinations (denials).

d. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats.

e. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization including referral to the PIHP for Medicaid specialty behavioral health services.

f. Process by which an Enrollee can access the Ombudsman, the State Long Term Care Ombudsman, the Michigan Medicaid Beneficiary Help Line, and 1-800-Medicare.

g. Information on all Contractor Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization.

h. How to contact immediate emergency assistance including adult protective services, suicide hotlines and other appropriate emergency services.

i. The procedures for an Enrollee to change plans or to disenroll from Contractor.

j. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of Contractor's plan.

10.2 Contractor's Call Center.

A. Contractor must operate a live-access, toll-free Enrollee Services telephone line during hours of operation seven (7) days a week. A toll-free TTY number or State relay service must also be provided.

B. Contractor must monitor its Enrollee Services telephone line to measure performance in areas such as, but not limited to:

a. Total call volume,

b. Average call length,

c. Average hold time in queue,

d. Abandonment rate,

e. And average response time to live interaction.

C. Contractor must provide a Quarterly report in a format as determined by MDHHS detailing Enrollee Service telephone line metrics.

D. ESRs must be available Monday through Friday, during normal business hours. Contractor may use alternative call center technologies on Saturdays, Sundays, and State and/or Federal holidays (except New Year's Day).

E. ESRs must be appropriately trained and qualified health professionals who, according to HIPAA laws, assess the Enrollee's issues and provide an appropriate course of action (i.e., medical advice, direct the Enrollee to an appropriate care setting, etc.).

F. Contractor must ensure that if care management needs are identified for an Enrollee that the ESR facilitating the Enrollee's issue has access to, and knows how to read and interpret Enrollee ICPs. Contractor must ensure that follow-up is timely and appropriate to assure the Enrollee's health and welfare.

10.3 Call Center Performance.

A. Contractor's ESRs' must answer eighty (80) percent of all Enrollee telephone calls within twenty (20) seconds.

B. Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting, before reaching a live person.

C. Contractor must limit the disconnect rate of all incoming calls to five (5) percent.

D. Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

10.4 Call Center Requirements.

A. ESRs must be able to respond to providers and Enrollees with information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

B. Contractor is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call center.

C. The coverage determination and Appeals call centers must operate during normal business hours in accordance with the Marketing Guidance for Michigan D-SNP plans.

D. Contractor must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations/redeterminations, outside of normal business hours, but is not required to have live enrollee service representatives available to accept such requests outside normal business hours.

E. Voicemail may be used outside of normal business hours provided that the message:

   a. Indicates that the mailbox is secure.

   b. Lists the information that must be provided so the case can be worked [e.g., provider identification, Enrollee identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request].

   c. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests.

   d. For Appeals calls related to Part D, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for Expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

F. Provider Accessibility and Nurse Advice Line.

   a. Contractor must require PCPs and specialty provider Contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

   b. Contractor must establish a toll-free nurse advice line, available twenty-four (24) hours a day, seven (7) days a week, through

which Enrollees may obtain medical guidance and support from a nurse.

c. Contractor must ensure that the nurses staffing the nurse advice line will be able to obtain physician support and advice by contacting Contractor's medical director or equally-credentialed designee, if needed.

11. Marketing, Outreach and Enrollee Communication Standards.

11.1 General Requirements.

A. Contractor is subject to rules governing Marketing, Outreach, and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. § 422.111, Part 422 Subpart V, § 423.120(b) and (c), § 423.128, Part 423 Subpart V, and § 438.10 et seq.; and the Medicare Communications and Marketing Guidelines (MCMG) MDHHS Marketing Requirements for HIDE SNPs with the following additional requirements or clarifications:

B. All information must be true and fair and maintain the integrity of HIDE SNP program. Communication practices that deceive or mislead the public or disparage a competing Contractor are strictly prohibited.

C. Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that the Enrollee or Potential Enrollee must enroll with Contractor in order to obtain benefits or in order not to lose benefits or that Contractor is endorsed by CMS, Medicare, Medicaid, the federal government, MDHHS or similar entity.

D. All written marketing materials and Enrollee Notices must be developed with the goal to assist Potential Enrollees and Enrollees in making an informed choice, and must be clear, concise, accurate and written in a culturally competent manner that the target population can easily understand. Materials, communications, and Notices must be available in alternate formats and languages to meet the accessibility needs of individuals with disabilities and limited English proficiency and meet the information requirements included but not limited to those detailed in 42 C.F.R. § 438.10.

E. Contractor must receive prior approval of designated marketing and Enrollee Communications materials in categories of materials that MDHHS requires to be prospectively reviewed.

F. Contractor materials may be designated as eligible for the File & Use process, as described in 422.2261(b)(3) and will therefore be exempt from prospective review and approval by MDHHS.

G. Contractor will submit materials as directed by CMS and MDHHS for review by the appropriate agency via the CMS Health Plan Management System (HPMS) Marketing Review Module.

H. Contractor is responsible for ensuring compliance with all applicable Federal and State laws and regulations.

   a. This includes monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities.

   b. Failure to comply with applicable rules may result in compliance and/or enforcement actions, including, but not limited to, intermediate sanctions and/or civil money penalties.

   c. Contractor may impose additional restrictions on subcontractors, downstream entities, and/or delegated entities, provided they do not conflict with the requirements outlined in regulations or the MCMG.

I. For the first year of the HIDE SNP program, Contractor may not begin marketing activity until Contractor has entered into this Contract, passed MDHHS' Readiness Review process, obtained all necessary CMS approvals, and is connected to Enrollment and payment systems such that Contractor is able to exchange payment and enrollment information with CMS and MDHHS as required.

11.2 Marketing Plan.

A. Upon request, Contractor must present annually its Marketing Plan that must detail all marketing activities and materials to MDHHS for review and approval.

B. Contractor must specify the methods it will use to ensure all materials are accurate and does not mislead, confuse, or defraud Potential Enrollees, Enrollees or the State.

C. Contractor must make available to MDHHS annually and upon request, current schedules of all marketing, outreach, health

education and health promotion events conducted by Contractor to provide information to Enrollees or Potential Enrollees.

D. Contractor must make available to MDHHS annually and upon request, information about sponsorships of events or activities in Michigan, including those funded by Contractor's Corporate entity, along with any collateral information about the sponsored event and sponsorship level.

11.3 Outreach to Potential Enrollees.

A. Contractor's outreach to Potential Enrollees must be consistent with applicable Federal rules for Medicare Advantage plans regarding, but not limited to, marketing, sales, agents, brokers, enrollment periods, and beneficiary contact.

B. Contractor must ensure that marketing representatives are versed in and adhere to Medicaid policy regarding beneficiary enrollment and disenrollment as stated in 42 C.F.R. §438.56.

   a. This policy includes, but is not limited to, requirements that enrollees do not experience unreasonable barriers to disenroll, and that Contractor must not act to discriminate on the basis of adverse health status or greater use or need for health care services.

   b. Marketing representatives must not state or imply that continuation of Medicaid benefits is contingent upon enrollment in Contractor's plan.

   c. Contractor must periodically review and assess the knowledge and performance of its marketing representatives.

C. Information obtained by Contractor from MDHHS's eligibility verification system must not be used by Contractor for marketing purposes.

D. Contractor must comply with the Marketing, branding, incentive, and other relevant guidelines and requirements established by MDHHS, State, and 42 CFR § 438.104.

E. Contractor may reach out to former members of their plan, who have been disenrolled due to loss of Medicaid eligibility, to assist them in enrolling in health coverage, provided it does not violate applicable marketing rules prohibiting discrimination.

a. Contractor would not be in violation of the marketing restrictions of the HIPAA Privacy Rule or the Medicaid marketing rules at 42 CFR Section 438.104 by sending communications to its former members about their options for health coverage through the HIDE SNP including that Contractor's own plan options, as this would not be marketing to currently enrolled HIDE SNP beneficiaries.

11.4 Requirements for Submission, Review, and Approval of Materials.

A. Contractor is required to comply with all requirements set forth in 42 CFR 422.2267(a). which sets forth the contractor's marketing, outreach, and enrollee communication materials.

11.5 Requirements for the Submission, Review, and Approval of Materials

A. Contractors must receive prior approval via HPMS of marketing and Enrollee Communications materials as designated by MDHHS. MDHHS may conduct additional types of review of Contractor Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

a. Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits.

b. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

c. "For cause" review of materials and activities when complaints are made by any source, and MDHHS determines it is appropriate to investigate.

d. "Secret shopper" activities where MDHHS requests Contractor materials, such as Enrollment packets.

B. The multi-plan submission process in HPMS is not applicable to D-SNP-only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes enrollee-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization or a Y number for materials the third-party provides to D-SNP enrollees in D-SNP-only contracts. The material must be submitted in HPMS using a separate material ID number for the D-SNP-only contract and that material ID number must be included in the material.

C. Materials that contain reference to Michigan Medicaid program benefits or any Michigan Medicaid program must be submitted to HPMS for MDHHS review and approval prior to use. MDHHS may request Ad Hoc reports and/or information from Contractor. Contractor must fulfill these requests within thirty (30) calendar days of the date of the agreed upon business requirements unless otherwise agreed upon by MDHHS and Contractor

D. MDHHS may request Ad Hoc reports and/or information from Contractor. Contractor must fulfill these requests within thirty (30) calendar days of the date of the agreed upon business requirements unless otherwise agreed upon by MDHHS and Contractor.

11.6 Integrated Enrollee Materials.

A. Contractor must comply with integrated materials required of Applicable Integrated Plans, in a format to be determined by MDHHS, to include:

a. Annual Notice of Change (ANOC) - Contractor must send a state-specific ANOC cover letter to enrollees transitioning from an Integrated Care Organization or a Coordination Only D-SNP operated by Contractor to Contractor's HIDE SNP. MDHHS will provide a template for the cover letter.

b. Member Handbook.

c. Summary of Benefits (SOB).

d. Provider and Pharmacy Directory (PPD).

e. List of Covered Drugs (LOCD).

f. Member ID Card.

B. For HIDE SNP Enrollments, Contractor must send the following materials to the Enrollee within ten (10) calendar days of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date of coverage, whichever occurs later. Materials will be further detailed in Marketing Guidance for Michigan HIDE SNPs.

a. A Medicare and Medicaid integrated HIDE SNP-specific summary of benefits.

b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy

products provided under the HIDE SNP, or a distinct and separate Notice on how to access this information online and how to request a hard copy.

c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and optional benefits as described in Section 3, or a distinct and separate Notice on how to access this information online and how to request a hard copy.

d. Proof of health insurance coverage so that the Enrollee may begin using Contractor services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits. NOTE: This proof of coverage is not the same as the Member Handbook/Evidence of Coverage document described in the Marketing Guidance for Michigan HIDE SNPs. The proof of coverage may be in the form of an Enrollee ID card or a welcome letter. As of the effective date of Enrollment, Contractor's systems must indicate active membership.

e. A welcome letter.

f. The charges for which the Enrollee will be liable for (e.g., Patient Pay Amount for Nursing Facility Care, or payments for non-authorized or non-covered services) in the welcome letter.

g. A provider letter for Enrollees to take with them when they go to appointments that explains the Enrollee's new benefit plan, continuity of care requirements, instructions for the provider to bill for services, and information on how to join Contractor's provider network. A model provider letter will be provided to Contractors by MDHHS.

h. A single ID card for accessing all covered Benefits and Services under Contractor.

i. A Member Handbook (Evidence of Coverage), or a distinct and separate Notice on how to access the Member Handbook online and how to request a hard copy.

j. The Enrollee's authorization for the disclosure and exchange of necessary information between Contractor, State, PIHP, and CMS.

k. The requirements for use of Contractor's network providers. Contractor must obtain an acknowledgment (oral or written) during the assessment process by the Enrollee that he or she understands that care will be received through designated providers except for Emergency Services and urgently needed care.

l. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if Contractor has not yet provided the ID card).

11.7 Websites and Social Media.

A. Contractor is required to maintain a website to facilitate dissemination and access of information electronically to Enrollees, Potential Enrollees, and Network Providers as set forth in 42 CFR 422.2265 which includes the Medicare Advantage website requirements.

B. Websites must comply with all terms of this contract and can be used to provide information about the health plan and/or the HIDE SNP program.

C. Websites are subject to the periodic review and approval by MDHHS.

D. In addition to the requirements set forth in 42 CFR 422.2265, the contractor's website must include:

a. A link to MDHHS' website for the HIDE SNP program,

b. Contact information for the MI Options program,

c. Contact information for the MI Community, Home, and Health Ombudsman (MI CHHO) and the State Long Term Care Ombudsman.

E. Contractor may use social media to promote events and activities and share educational materials.

a. Contractor is responsible for monitoring all public comments for appropriateness and sensitivity of information and/or language.

b. All social media pages are subject to the periodic review and approval by MDHHS.

11.8 Use of the MICH Program Logo.

A. All use of the MICH program logo must meet the following requirements:

a. Contractors must submit materials that contain the MICH program logo for MDHHS review in HPMS.

b. The MICH program logo will not be used to imply sponsorship or endorsement on materials distributed by Contractor.

c. The MICH program logo will not be used in any manner that may possibly disparage, bring into disrepute, or negatively reflect on the MICH program or in connection with any products or services that may possibly diminish or damage the goodwill of the MICH program or MDHHS.

d. Contractor may not include the HIDE SNP MICH program logo on educational materials.

e. Contractor may not use the MICH program logo on business cards.

f. The MICH program logo provided by the State to Contractors cannot be altered without the express permission of MDHHS.

g. The MICH program logo must not be used as a feature or design element, or be incorporated into any other service mark or logo.

h. The MICH program logo must stand by itself so as to avoid unintended associations with any other objects, including, but not limited to, text, photographs, illustrations, borders, and edges. The width of the blank space surrounding the logo must be equal to 1/3 of the size of the symbol that is displayed (e.g., if the symbol is 30 pixels across, it must have 10 pixels of blank space above, below and on each side). The logo and Contractor's logo must retain their natural proportional size and must not appear stretched, distorted, or pixelated. The MICH program logo must appear in color whenever Contractor's logo is displayed in color on the same document or material.

i. Contractor's downstream contractors and related entities may not use the MICH program logo unless the document has been approved through HPMS or the State approved process.

B. The State of Michigan, through MDHHS, retains the right to change these guidelines at any time.

11.9 Requirements of Dissemination of Materials.

A. Contractor must distribute all materials to its entire Service Area as referenced in Section 1.3; and must convene all educational and marketing/sales events at sites within Contractor's Service Area that are physically accessible to all Enrollees or Potential Enrollees, including persons with disabilities and persons using public transportation.

B. In addition to providing all materials required by 42 CFR 422.2267(e) and complying with all CMS requirements, timelines, specifications, and model materials, Contractor is required to use approved model materials for the following materials:

a. An integrated Evidence of Coverage (EOC)/Enrollee Handbook, or a distinct and separate Notice on how to access the Enrollee Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.111, and 423.128; includes information about all Medicare and Medicaid Covered Services, consistent with the model documents developed by MDHHS and CMS, and meets the requirements of this Contract.

b. A combined Provider and Pharmacy Network Directory, or a distinct and separate Notice on how to access this information online and how to request a hard copy, that is consistent with the model document developed by MDHHS and meets the requirements of this Contract.

c. A single ID card for accessing all Medicare and Medicaid Covered Services under HIDE SNP program that uses the model document developed by MDHHS.

d. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and MDHHS's outpatient prescription drug benefit and that uses the model document developed by MDHHS, or a distinct and separate Notice on how to access this information online and how to request a hard copy.

e. Existing and future model materials as prepared and issued by MDHHS for use in the HIDE SNP program.

11.10 Member Handbook Requirements.

A. The Member Handbook must include the following items, consistent with model materials provided by MDHHS and CMS:

a. Enrollee rights (see Appendix I).

b. How to obtain access to specialty, behavioral health, pharmacy and LTSS providers.

c. The Enrollee's right to select a PCP and how to change PCP.

d. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

i. What constitutes an Emergency Medical Condition, Emergency Services, Urgent Care and Post-Stabilization Care Services, with reference to the definitions is 42 C.F.R. §438.114(a) and 42 C.F.R. §422.113.

ii. The fact that prior authorization is not required for Emergency Services.

iii. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent.

iv. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract.

v. That the Enrollee has a right to use any hospital or other setting for emergency care.

vi. The Post-Stabilization Care Services rules at 42 C.F.R. §422.113(c).

e. Information about Advance Directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including:

i. Enrollee rights under the law of the State of Michigan.

ii. Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

iii. That complaints concerning noncompliance with the Advance Directive requirements may be filed with MDHHS.

iv. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee.

v. Contractor must update materials to reflect any changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

f. How to obtain assistance from ESRs.

g. How to file Integrated Grievances and Integrated Appeals, including, without limitation:

i. Integrated Grievance, Integrated Appeal and State Fair Hearing procedures and timeframes.

ii. Toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone for expedited Appeals only (only Expedited Appeals may be received telephonically for Appeals through the State Fair Hearing Process).

iii. That when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing.

iv. How the Enrollee can identify who the Enrollee wants to receive Adverse Benefit Determination Notices/Coverage Decision Letters.

v. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as MDHHS or CMS may identify, including an Ombudsman.

h. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers.

i. How and where to access any benefits that are available under the Michigan Medicaid State plan or applicable waivers but are not covered under the Contract.

j. How to change providers.

k. How to disenroll voluntarily.

l. Notice of privacy practices.

m. Eligibility requirements for HIDE SNP program enrollment.

n. Self-referral services.

o. Explanation that the HIDE SNP program identification (ID) card replaces the Medicare and Medicaid cards and that Enrollees should keep their original Medicare and Medicaid cards.

p. The right to change plans.

q. Non-discrimination requirements.

r. How to contact MDHHS with concerns about Contractor.

s. The structure and operation of any physician incentive plans Contractor may have in place.

t. The structure and operation of Contractor.

u. How to access Contractor's Provider and Pharmacy Network Directory.

v. The name of Contractor's parent company and any doing business as name that may be used; toll-free Enrollee services and care coordination and nurse advice twenty-four (24) hour service lines; and any other content required by State or federal regulation.

w. Information on how to contact their Care Coordinator.

11.11 Requirements for the Provider and Pharmacy Directory.

A. Maintenance and Distribution.

a. Contractor must maintain a combined Provider and Pharmacy Network Directory that uses the model document developed by MDHHS.

b. Contractor must provide the Provider and Pharmacy Network Directory in a manner agreeable to the Enrollee either by mail or by utilizing Contractor's website.

i. Provider directories must be made available on Contractor's website in a machine-readable file.

ii. 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.

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

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

d. Contractor must ensure an up-to-date copy is available on Contractor's website, updated no later than 30 calendar days after Contractor receives updated provider information, consistent with the requirements at 42 C.F.R. §§ 422.411(b)(3); 422.2267(e)(11); 423.128(d); 438.10(h)(3); and that the provider network information included in a paper provider directory is updated at least monthly.

i. When there is a significant change to the network, Contractor must provide Notice to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual.

ii. Consistent with Section XII.A.8 of this Contract and 42 C.F.R. § 422.111(e) and 422.2267(e)(12), Contractor must make a good faith effort to provide written Notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all Enrollees who regularly use the provider or pharmacy's services; irrespective of whether the termination was for cause or without cause.

iii. If a contract termination involves a PCP, all Enrollees who are patients of that PCP must be notified.

e. Contractor must include written and oral offers of such Provider and Pharmacy Network Directory in its outreach and orientation sessions for new Enrollees.

B. Content of Provider and Pharmacy Network Directory.

a. As applicable, network providers with training in and experience treating:

   i. Individuals with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness.

   ii. Individuals who are homeless.

   iii. Individuals who have hearing, visual, or other sensory or cognitive impairments.

   iv. Individuals with co-occurring disorders.

   v. Other specialties.

b. For behavioral health providers, training in and experience treating trauma, child welfare, and substance use.

c. For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, office hours.

d. Whether the health care professional or non-facility-based network provider has completed cultural competence training.

e. Whether the network provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment.

f. Whether the provider is accepting new patients as of the date of publication of the directory.

g. Whether the network provider is on a public transportation route.

f. Any languages other than English, including ASL, spoken by network providers or offered by skilled medical interpreters at the provider's site, and, as applicable, whether the provider has access to language line interpreters.

g. The directory must include, at a minimum, the following information for all pharmacies in Contractor's pharmacy network:

   i. The names, addresses, and telephone numbers of all current network providers and pharmacies.

ii. Whether the pharmacy provides an extended day supply of medications.

iii. Instructions for the Enrollee to the contact Contractor's toll-free Enrollee Services telephone line (as described in Section XII.A.8.) for assistance in finding a convenient pharmacy.

iv. Contractor must periodically audit at least a sample size of its Provider directory for accuracy of directory information, including and not limited to contact information, physical addresses, acceptance of new patients, and accessibility.

v. Contractor must retain documentation of such audit to be made available to MDHHS upon request. At a minimum, directory information for all PCPs, OB/GYNs, hospitals, LTSS, dental, and outpatient behavioral health providers must be audited at least annually.

12. Enrollee Unified Grievances and Appeals

12.1 General Requirements.

A. Contractor must establish and maintain integrated, unified, internal processes for Enrollees for grievances and appeals, including organization determinations, and reconsiderations.

B. Consistent with State policy, Contractor's Integrated and Unified Grievance and Appeal system and processes must be in compliance with the terms of 42 CFR §§ 422.629 – 422.634, 438.210, 438.400, and 438.402 as may be amended (the "Unified G&A Regulations"), and MCL 500.2213, (the Unified Grievance and Appeal System"). This includes without limitation:

a. Grievances and Appeals systems that meet the requirements described in 42 CFR §422.629.

b. An Integrated Grievance process that complies with 42 CFR §422.630.

c. A process for making Integrated Organization Determinations consistent with 42 CFR §422.631.

d. Continuation of benefits while an Integrated Reconsideration is pending consistent with 42 CFR §422.632.

e. A process for making Integrated Reconsiderations consistent with 42 CFR §422.633.

f. A process for effectuation of decisions consistent with 42 CFR §422.634.

C. Contractor must have written policies and procedures governing the resolution of integrated grievances, integrated organization determinations, and integrated reconsiderations.

D. Contractor must seek MDHHS' approval of Contractor's integrated grievance and appeal policies prior to implementation.

E. Contractor's written integrated grievance and appeal policies and procedures must meet the following requirements:

a. Contractor must administer internal integrated appeal procedures according to the requirements of MCL 500.2213, 42 CFR 438.400 – 438.424 (Subpart F) and 42 CFR §§ 422.629 – 422.634.

b. Contractor must cooperate with the DIFS in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act", as may be amended from time to time, for appeal of a Medicaid service.

c. Contractor must have only one level of internal integrated appeals for Enrollees.

d. Contractor's policies must allow any Enrollee the opportunity to appeal Contractor's adverse determinations related to any covered service.

e. Enrollees may authorize in writing third parties to submit integrated grievances, integrated organization determinations and integrated appeals on their behalf. Providers do not require a written authorization to pursue an appeal or submit a grievance

f. Contractor must be able to distinguish between integrated organization determinations and integrated appeals related to Medicare covered services and appeals related to Medicaid covered services and ensure that appeals are appropriately processed for each type of service.

g. Internal integrated appeals regarding overlapping services (including, but not limited to, home health, durable medical equipment, and skilled therapies, but excluding Medicare Part D) decided adversely to an Enrollee will be auto-forwarded to the Federal Independent Review Entity (IRE) by Contractor, and the Enrollee may also file a request for a hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). If an integrated Appeal is sent to the IRE and filed with MOAHR, any determination in favor of the Enrollee will bind the entity and will require payment by the entity for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on appeal.

h. Contractor must make a determination on standard integrated Appeals as expeditiously as the member's health requires, but in all cases not later than 30 calendar Days after an Appeal is received from an Enrollee and 72 hours for expedited integrated appeals according to 42 CRF 422.633(f). Integrated appeals may be extended for a period of time that must not exceed 14 Days if (1) the Enrollee requests the extension or (2) Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest. Contractor may not extend the time frame for appeal decisions other than as described in this Section.

i. If Contractor extends the timeframes of an appeal not at the request of the Enrollee, it must:

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

   ii. Within two Days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file an expedited integrated Grievance if he or she disagrees with that decision.

   iii. Resolve the integrated Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

F. Contractor must give Enrollees timely and adequate notice of an Adverse Benefit Determination in writing consistent with the requirements in 42 CFR §§ 422.631, 438.02, 438.10, 438.404, and this Contract. Contractor must use the OMB-Approved Applicable

Integrated Plan "Coverage Decision Letter," along with other resources and guidance available, at:

https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements.

The notice must explain the following:

a. The Adverse Benefit Determination the Contractor has made or intends to make.

b. 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.

c. The Enrollee's right to request an integrated appeal of the Adverse Benefit Determination, including information on exhausting Contractor's internal appeal and the right to request a State Fair Hearing.

d. The procedures for exercising their appeal rights, the circumstances under which appeal can be expedited and how to request it.

e. The Enrollee's right to have benefits continue pending resolution of the integrated appeal, how to request that benefits be continued, and, if allowed under State policy, the circumstances under which the Enrollee may be required to pay the costs of these services.

f. Contractor must mail the Adverse Benefit Determination notice within the timeframes specified in 42 CFR §§ 422.631(d) and 438.404(c).

g. Contractor must allow Enrollees 65 Days from the date of the Adverse Benefit Determination notice in which to file an integrated Appeal.

h. 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.

i. Contractor must acknowledge receipt of each integrated appeal in writing.

j. Contractor must ensure that the individuals who make decisions on integrated appeals are individuals who:

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

ii. Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the appeal involves a clinical issue.

iii. Must take into account all comments, documents, records and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

G. Contractor must provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as integrated appeals to establish the earliest possible filing date for the integrated appeal.

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

I. Contractor must provide the Enrollee and their representative the Enrollee's case file, including medical records, other documents, and records, and any new or additional evidence considered, relied upon, or generated by Contractor in connection with the integrated appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for integrated appeals.

J. Contractor must consider the Enrollee, their representative, or estate representative of a deceased Enrollee as parties to the Appeal.

K. Contractor must notify the Enrollee in writing of Contractor's decision on the integrated appeal.

a. Contractor must submit in writing to MDHHS any request to make changes to procedures relating to its integrated Grievance and Appeal System. MDHHS must review and approve the request prior to implementation of any change. Request for changes must allow adequate time for review and approval by MDHHS. When the change requires written notice to the Enrollees, the change cannot take effect until such notice is approved.

L. Contractor must provide information specified in 42 CFR §§ 422.629(j) and 438.10(g)(2)(xi) about its integrated grievance and appeal system to all providers and subcontractors at the time the enter into a contract. Contractor and First Tier, Downstream and Related Entities agree to be fully compliant with all State and federal laws, regulations, and policies governing the integrated Grievance and Appeal System.

12.2 Notice to Enrollees of Appeal Procedure.

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

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

a. How to file an integrated appeal with Contractor.

b. The internal integrated appeal process.

c. The Enrollee's right to a Fair Hearing with the State after Contractor's internal appeal process has been exhausted.

12.3 Notice to Enrollees of Adverse Benefit Determinations.

A. When Contractor makes a decision subject to appeal, as defined in this Contract, Contractor must provide the written Adverse Benefit Determination notice, called the Coverage Decision Letter, to the Enrollee and the requesting provider, if applicable. Contractor must mail the notice within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Services, within the timeframes specified in 42 CFR §§ 422.631(d), 431.211,431.213, and 431.214.

b. For denial of payment, within the time frames specified in 42 CFR §422.631(d).

c. For expedited and standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR §§ 422.631(d) and 438.210(d).

B. If Contractor meets the criteria set forth for extending the timeframe for service authorization decisions consistent with 42 CFR §§ 422.631(d)(2)(ii) and 438.210(d)(1)(ii), it must:

a. Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file an expedited integrated grievance if he or she disagrees with that decision.

b. Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expire.

C. For service authorization decisions not reached within the timeframes specified in 42 CFR §§ 422.631(d) and 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

D. Contractor must continue the Enrollee's benefits if all of the following conditions apply:

a. The Enrollee files the request for an appeal timely in accordance with 42 CFR §§ 422.633(d) and 438.402(c)(1)(ii) and (c)(2)(ii).

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

c. The services were ordered by an authorized provider.

d. 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:

i. Within 10 Days of Contractor's mailing the Adverse Benefit determination notice, or

ii. The intended effective date of Contractor's proposed Adverse Benefit determination notice.

E. If 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:

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

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

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

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

e. If Contractor or State Fair Hearing Officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, 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.

f. If 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, Contractor must pay for those services.

12.4 CSHCS Appeals.

A. The Internal Integrated appeals process described herein applies to appeals related to CSHCS services, with the following exceptions:

B. Contractor must make a determination on CSHCS appeals not later than 10 days after an appeal is received.

C. When reviewing appeals for Enrollees in CSHCS, Contractor must utilize an appropriate subspecialist provider to review decisions to deny, suspend, terminate, or limit subspecialist provider services.

12.5 State Medicaid Appeal Process.

A. The State must maintain a Fair Hearing process to ensure Enrollees have the opportunity to appeal decisions directly to the State. Any Enrollee dissatisfied with a State agency determination denying an

Enrollee's request to transfer Contractors/disenroll has access to a State Fair Hearing.

B. Contractor must include the Fair Hearing process as part of the written internal process for resolution of appeals and must describe the Fair Hearing process in the member handbook. The parties to the State Fair Hearing may include 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 Contractor has upheld its Adverse Benefit Determination.

   a. If Contractor fails to adhere to the required appeals notice and timing requirements in 42 CFR §438.408, the Enrollee is deemed to have exhausted Contractor's Appeals process.

D. Contractor must allow the Enrollee 120 Days from date of Contractor's Appeal resolution notice to request a State Fair Hearing.

12.6 Integrated Grievances.

A. Contractor's integrated grievance policies and procedures must meet the following requirements:

   a. Contractor must administer internal integrated grievance procedures according to the requirements of MCL 500.2213, 42 CFR 438.400 – 438.424 (Subpart F) and 42 CFR §422.630 .

   b. An Enrollee may file an integrated grievance with Contractor at any time.

   c. Contractor must timely acknowledge receipt of each integrated grievance in writing.

   d. Contractor must investigate and resolve integrated standard Grievances within 30 Days of the submission of an integrated Grievance according to 42 CFR § 422.630(e) and 24 hours for expedited grievances according to 42 CFR § 422.630(d).

   e. Contractor must ensure that the individuals who investigate integrated grievances are individuals who:

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

ii. Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the grievance involves the denial of expedited resolution of an appeal or a clinical issue.

iii. Must take into account all comments, documents, records and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in an initial Adverse Benefit Determination.

iv. Contractor must notify the Enrollee in writing of Contractor's findings on the integrated grievance.

B. Contractor must inform Enrollees about Contractor's internal integrated grievance procedures at the time of initial enrollment and any other time an Enrollee expresses dissatisfaction by filing an integrated grievance with Contractor.

a. The integrated grievance procedure information must be included in the member handbook and must explain:

i. How to file an integrated grievance with Contractor.

ii. The internal integrated grievance resolution process.

C. HIDE SNP Billing Issues and Complaint Resolution.

a. When a complaint or billing issue is received by MDHHS, MDHHS will initiate contact with the Contractor.

b. A beneficiary complaint is any situation in which a beneficiary or 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 vision, dental, behavioral health, routine healthcare, transportation assistance, and/or prescriptions.

c. For the purposes of this subsection, a complaint should be treated as a grievance. A complaint under this subsection may or may not be a complaint under Section 17 and should be evaluated pursuant to that section.

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

e. 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.

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

f. A provider complaint is any situation in which a provider expresses a concern about the business operations of Contractor, not including billing issues.

g. Contractor must provide MDHSHS with an update regarding the resolution of provider complaints within 30 weeks of receipt.

h. A provider billing complaint is any situation in which a provider expresses a concern about the timeliness or accuracy of payment by Contractor to the provider.

D. Integrated Grievance and Appeals Records.

a. Contractor and its subcontractors as applicable, must maintain records (logs) of all integrated grievances and appeals.

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

      (a) A general description of the reason for the integrated appeal or grievance.

      (b) The date received.

      (c) The date of each review or, if applicable, review meeting.

      (d) Resolution at each level of the integrated appeal or grievance, if applicable.

      (e) Date of resolution at each level, if applicable.

      (f) Name of the covered person for whom the integrated appeal or grievance was filed.

b. The record must be accurately maintained in a manner accessible to the State and available upon request to MDHHS.

c. At the direction of MDHHS, Contractor will submit:

i. A quarterly summary of integrated grievances received and the outcomes of those grievances.

ii. A quarterly summary of internal integrated appeals received and the outcomes of those appeals.

iii. A quarterly summary of integrated appeals to the Michigan Office of Administrative Hearings and Rules (MOAHR).

iv. A quarterly summary of integrated appeals to DIFS.

13 Medicaid Provider Payment.

13.1 Timely Provider Payments.

A. 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.

B. Contractor must pay 95 percent of all Clean Claims from practitioners within 30 Days of the date of receipt.

C. Claims from LTSS providers will be paid within thirty (30) calendar days of the date of receipt of the "clean Claim" or other form of itemized Claim including a paper or electronic invoice or receipt for services or a service/work log.

D. Contractor and its providers, including Indian Health Care Providers, may by mutual agreement, in writing, establish an alternative payment schedule.

E. Contractor must pay 99 percent of all Clean Claims from practitioners within 90 Days of the date of receipt.

F. Contractor must have ≤1% of ending inventory over 45 Days old and ≤12% denied claims.

G. Contractor must ensure that the date of receipt is the date 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.

H. Contractor must make all payments to both network and Out-of-Network providers.

I. Contractor will not be responsible for any payments owed to Providers for services rendered prior to a Beneficiary's effective enrollment date with Contractor.

J. Contractor is responsible for annual IRS form 1099, Reporting of Provider Earnings, and must make all collected data available to MDHHS and, upon request, to CMS.

13.2 Alternative Payment Methods.

A. Consistent with MDHHS's goals to move reimbursement from fee-for-service (FFS) to value-based payment models, Contractor must demonstrate the utilization of the Alternative Payment Models using the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework.

B. 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 Enrollees. Contractor recognizes the importance of establishing value-based payment models that improve health equity and do not further exacerbate health disparities. Alternative Payment Models include, but are not limited to:

   a. Pay-for-Reporting and Pay-for-Performance arrangements.

   b. Shared Savings arrangements.

   c. Bundled payments or Episode of Care models.

   d. Total or Limited Capitation models

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

C. As directed by MDHHS, Contractor will report on HIDE SNP's value-based contracts and will comply with payment reform goals and threshold targets established by MDHHS.

13.3 Electronic Billing Capacity.

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

B. Contractor must ensure Providers bill Contractor using the same format and coding instructions required for the Medicaid FFS programs according to Medicaid Policy.

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

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

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

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

13.4 Provider Preventable Conditions.

A. Contractor is prohibited from making payment to a Provider for provider preventable conditions that are outlined in the Michigan State Plan.

B. Contractor must require all Providers to report provider-preventable conditions associated with claims for payment or Enrollee treatment for which payment would otherwise be made in accordance with federal Medicaid regulations.

C. Contractor must report all identified provider-preventable conditions as directed by MDHHS.

13.5 Different Types of Provider Payments.

A. Hospital Payments.

a. Contractor must pay Out-of-Network hospitals for all emergency and authorized Covered Services provided to Contractor's Enrollee(s) outside of Contractor's Provider Network.

i. Out-of-Network hospital claims must be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid providers.

ii. Hospital payments must include payment for the DRG (as defined in the Medicaid Institutional Provider Chapter)

outliers, as applicable, and capital costs at the per-discharge rate.

iii. Hospital payments must include the applicable hospital reimbursement (e.g., Graduate Medical Education) in the amount and on the schedule defined by MDHHS.

B. LTSS Payments/NF.

a. Contractor must ensure ninety-nine percent (99%) of clean claims from these providers are adjudicated within fourteen (14) calendar days of receipt of the clean claim, and one hundred percent (100%) are adjudicated within thirty (30) calendar days, for covered services rendered to covered Members who are enrolled with Contractor at the time the service was delivered.

b. Where the service is covered by Medicare, the fourteen (14) calendar day timeframe begins on the date of Medicare adjudication.

c. MDHHS requires Contractor to implement uniform billing practices and claims submissions processes for NF/LTSS.

d. Contractor must participate in working sessions with MDHHS and other Managed Care program contractors to develop and implement such uniform billing practices.

C. Consideration will be made towards the development of uniform billing procedures especially for small providers who are not familiar with electronic billing through Medicaid Managed Care Organizations.

D. Contractor must develop, train providers on, and implement uniform practices in conjunction with MDHHS and the other selected Managed Care program contractors.

E. Contractor does not require Department approval to implement arrangements that pay at least the current Medicaid FFS rate and are mutually agreed upon by the provider and Contractor.

13.6 Payment Resolution.

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 Contractor's Appeal process by entering into arbitration or other alternative dispute resolution processes.

C. Arbitration and Rapid Dispute Resolution for Hospital Providers.

14 Financial Requirements.

14.1 Financial Viability.

A. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 C.F.R. § 422.402, and 42 C.F.R. § 438.116, Contractor must meet all State and federal financial soundness requirements. These may include:

a. Contractor must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the entity's debts, if the entity becomes insolvent.

b. Contractor must produce adequate documentation satisfying the State that it has met its Solvency requirements.

c. Contractor must comply with all HMO statutory requirements for fiscal soundness and MDHHS will evaluate Contractor's financial soundness.

d. Contractor must also maintain reserves to remain solvent for a forty-five (45) calendar day period and provide satisfactory evidence to the State of such reserves.

14.2 Solvency Requirements.

A. Contractor will be required to meet Solvency requirements as specified in MDHHS procurement, including rules developed by the DIFS.

B. DIFS is responsible for the licensing and monitoring of the financial Solvency of Health Insuring Corporations (HICs).

C. Contractor is required to have a certificate of authority to operate as an HMO in accordance with MCL 500.3505.

14.3 Other Financial Requirements.

A. Contractor must cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

B. The IMD exclusion is found in section 1905(a)(B) of the Social Security Act, which prohibits: payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" Except for: inpatient psychiatric hospital services for individuals under age 21.

C. An in-lieu of service is a service that is not included under the State plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service. Medicaid payment for IMD services under this authority is limited to 15 days per month.

14.4 Medical Loss Ratio (MLR).

A. Contractor is subject to a minimum MLR of 85 percent.

B. The MLR provisions apply on a contract-specific basis and include revenue and expense experience applicable to Enrollees included under the Contract.

C. Contractor must submit to MDHHS a consolidated MLR report for its Medicaid population for each MLR reporting year, as directed by MDHHS and in accordance with 42 CFR 438.8.

D. Contractor must use the reporting tool provided by MDHHS for MLR reporting requirements for each fiscal reporting year of the Contract.

E. Failure of Contractor to meet the minimum MLR will result in remittance of funds from Contractor.

a. A corrective action plan will be required from the contractor that addresses the contractor's plan to elevate to 85%.

b. Within 90 Days of MDHHS' notice to Contractor of its failure to meet the minimum MLR, Contractor must remit back to MDHHS a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 85% multiplied by the revenue paid to Contractor during the Contract year.

F. Rebates paid to MDHHS will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care Program.

14.5 Medicaid Provider Audits, Overpayments, and Recoveries.

A. 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 Contractor of the retroactive disenrollment.

    i. These disenrollments are identified with disenrollment reason code I and N, respectively, on the 834 daily enrollment file.

    ii. Contractor must not recoup money from Providers for individuals retroactively disenrolled for incarceration from the date that MDHHS notified Contractor of the retroactive disenrollment.

c. Contractor must complete post-payment reviews for individuals disenrolled by MDHHS due to death within 90 Days of the date MDHHS notifies Contractor of the Enrollee's death or within 90 Days of the date MDHHS notifies Contractor of disenrollment from the plan (if disenrollment notification is after notification of death).

    i. Disenrollments due to Death are identified with disenrollment reason code D on the 834 daily enrollment file.

    ii. For retroactive disenrollments due to loss of eligibility or other unspecified reason, Contractor must not automatically recoup payments made to providers; these disenrollments are identified with disenrollment reason code L and O, respectively, on the 834 daily enrollment file.

    iii. Recoupment of the capitation from Contractor is based on several eligibility and enrollment factors that may change after the Enrollee is disenrolled.

    iv. Contractors may not recoup from providers unless MDHHS recoups the capitation payment from Contractor and does not reimburse Contractor for the recouped capitation amount.

    v. 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 Contractor when the eligibility is corrected. MDHHS will not recoup the capitation payment from the provider for the retroactive time

period and Contractor is prohibited from recouping payments from providers.

vi. 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 Contractor's plan that is not supported by Medicaid eligibility.

vii. MDHHS will recoup capitation payments made for all months that are not supported by Medicaid eligibility.

viii. If 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.

ix. Contractor is prohibited from recouping payments from providers.

14.6 Hospital Access Agreement.

A. . Contractor must comply with the provisions of the Hospital Access Agreement executed by MDHHS and the hospitals. See MSA-01-28-Final Bulletin-Payment between Noncontracting Hospitals and Medicaid Health Plans.

B. To resolve claim disputes with non-contracted hospital providers, Contractor must follow the Rapid Dispute Resolution Process specified in the Medicaid Provider Manual.

a. This applies solely to disputes with noncontracted hospital providers that have signed the Hospital Access Agreement; noncontracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution Process.

C. At MDHHS direction, Contractor must go through the Rapid Dispute Resolution Process.

D. Non-Hospital Provider Dispute Resolution.

a. When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, Contractor is required to participate in a binding arbitration process.

i. Providers must exhaust Contractor's internal provider Appeal process before requesting arbitration.

ii. MDHHS will provide a list of neutral arbitrators that can be made available to resolve billing disputes. The list can be found at

https://www.michigan.gov/difs/utilization-review/approved-arbitrator-list

iii. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid

iv. Both parties agree to assume the burden of cost for presentation of their positions before the mediator.

15. Contract Compliance.

15.1 Contract Compliance Management.

A. An MDHHS Contract Manager will act as a liaison(s) between Contractor and MDHHS for the duration of the Contract. The MDHHS Contact Manager will:

a. Conduct site visits as determined necessary.

b. Review, approve, and monitor Contractor's policies and procedures as stated in this contract herein, including but not limited to, marketing, orientation and outreach, Grievance and Appeal.

c. Maintain a comprehensive list of Contractor submission requirements, as stated in this Contract herein, with due dates updated annually and as necessary, referred to as the 'Submission Requirements Matrix'. MDHHS reserves the right to modify the Submission Requirements Matrix at any time. Submission requirements may be added as they are identified throughout the contract period.

d. Inform Contractor of any discretionary action by MDHHS under the provisions of the Contract

e. Conduct comprehensive contract compliance reviews as an ongoing activity during the term of this Contract. The contract compliance review will focus on specific areas of health plan performance as determined by MDHHS. MDHHS will, at its discretion:

i. Evaluate, through inspection or other means, Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements as listed on the annual 'Submission Requirements Matrix', and the quality, appropriateness, and timeliness of services performed by Contractor and its Provider Network. MDHHS will provide Contractor with the written results of these evaluations.

ii. Conduct periodic audits of Contractor, which may include, but is not limited to, an annual independent external review and an annual site visit.

f. MDHHS must retain discretion to take immediate action where the health, safety or welfare of any Enrollee is imperiled or where significant financial risk is indicated.

g. To assist Contractor's Contract Manager, on an annual basis, and on an ad hoc basis, when changes occur or as directed by MDHHS, the Contractor must submit to MDHHS an overall organizational chart that includes senior and mid-level managers.

h. Oversight of Contractor and providers will be at least as rigorous as existing procedures for MDHHS's Medicaid 1915(c) waiver and managed care programs.

15.2 Agreement Remedies and Sanctions.

A. MDHHS will utilize a variety of means to assure compliance with Contract requirements.

B. If MDHHS determines that Contractor fails to comply with the terms of this Contract or any other applicable laws, MDHHS may impose monetary Sanctions and other Sanctions, on Contractor.

C. MDHHS will pursue remedial actions or improvement plans for Contractor to implement to resolve outstanding requirements if appropriate.

D. 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.

a. MDHHS, at its sole discretion, may establish an installment payment plan for payment of any monetary Sanction.

b. The determination of the amount of any monetary Sanction must be at the sole discretion of MDHHS, within the ranges set by MDHHS.

c. Self- reporting by Contractor will be taken into consideration in determining the amount of any monetary Sanction.

d. MDHHS will not impose any monetary Sanction where the non-compliance is directly caused by the MDHHS's action or failure to act or where a force majeure delays performance by Contractor.

e. MDHHS may employ contract remedies, monetary Sanctions and other Sanctions to address any Contractor non-compliance with the Contract.

f. Areas of non-compliance for which MDHHS may impose remedies, monetary Sanctions and other Sanctions include, but are not limited to, non-compliance with Contract requirements on the following issues:

i. Marketing practices.

ii. Member services.

iii. Provision of Medically Necessary, Covered Services.

iv. Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services.

v. Provider Networks.

vi. Provider payments.

vii. Encounter submission.

viii. Quality measure data submission.

ix. Grievance and Appeal requirements.

x. 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.

xi. Enrollee satisfaction.

xii. Healthy Behavior policy and operational process.

xiii. HCBS waiver requirements.

xiv. Performance standards including Quality Withhold, QIP, PIP, and other standards/benchmarks defined by MDHHS.

xv. Misrepresentation or false information provided to MDHHS, CMS, Providers, Enrollees, or Potential Enrollees.

xvi. Utilization Review Accreditation Commission (URAC) or NCQA Health Plan accreditation.

xvii. NCQA Health Equity Accreditation.

xviii. Certificate of Authority.

xix. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

g. MDHHS may utilize intermediate Sanctions (as described in 42 CFR 438 Subpart I) that may include the following:

i. Monetary Sanctions in the following specified amounts:

(a) A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with physician incentive plan requirements; or Marketing violations.

(b) A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

(c) A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

(d) A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging copayments in excess of the amounts permitted under the Medicaid program. The State will deduct from the Sanction the amount of overcharge and return it to the affected Enrollee(s).

h. 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 Department of Insurance and Financial Services (DIFS).

i. Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.

j. Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the Sanction.

k. 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.

l. Additional Sanctions allowed under State statute or regulation that address areas of non-compliance.

E. The State will give Contractor timely written notice for any intermediate Sanctions that specifies the basis and nature of the Sanction, in accordance with 42 CFR 438.710.

F. If intermediate Sanctions or general remedies are not successful or MDHHS determines that immediate termination of the Contract is appropriate, as allowed by Standard Contract Term, the State may terminate the Contract with Contractor. Contractor must be afforded a hearing before termination of a Contract under this Section can occur.

G. The State will give Contractor written notice of its intent to terminate, the reason for the termination and the time and place of the hearing.

H. After the hearing, the State will give 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.

a. For an affirming decision, give Enrollees of Contractor notice of termination and allow Enrollees to disenroll, without cause and choose another Contractor.

I. In addition to the Sanctions described above, MDHHS may impose monetary Sanctions for repeated failure of Contractor to meet the requirements of this Contract. The determination of the amount of such Sanction must be at the sole discretion of the MDHHS, within ranges set by MDHHS.

15.3 Non-Compliance.

A. MDHHS will monitor compliance with the terms of the Contract including issuance of Notices of non-compliance/enforcement.

B. Contractor agrees and understands that MDHHS may pursue tailored contractual remedies for non-compliance with this Contract.

C. At any time and at its discretion, MDHHS may impose or pursue one or more remedies for each item of non-compliance and will determine remedies on a case-by-case basis.

D. 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.

15.4 Notice and opportunity to cure for non-material breach.

A. 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.

B. Contractor will receive a formal notice of identified non-compliance.

C. 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.

D. Contractor's proposed cure of a non-material deficiency is subject to the approval of MDHHS.

E. 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.

15.5 Notice of Non-Compliance (NONC).

A. MDHHS may issue Notices of Non-Compliance to document small or isolated problems that Contractor must address to comply with this Contract.

B. Contractor is required to acknowledge receipt of the notice and respond in accordance with contract requirements.

C. No enforcement action or formal Corrective Action Plan is required at the time of NONC.

15.6 Enforcement Action Letter.

A. MDHHS will issue Enforcement Action Letters to Contractor:

a. Following a NONC for an existing issue if the problem persists or

b. Following a first offence of a larger or more concerning issue.

B. Enforcement Action Letters will contain information about compliance enforcement action, including but not limited to monetary Sanctions and other Sanctions and any necessary escalation of compliance enforcement action should the non-compliance continue.

C. Contractor is required to acknowledge receipt of the Letter and respond in accordance with the enforcement action specified in the Letter and the contract requirements listed in this section.

D. Receipt of an Enforcement Action Letter does not mean a formal Corrective Action Plan is required.

15.7 Corrective Action Plan (CAP).

A. MDHHS may issue a CAP to correct or resolve a material deficiency, finding, event, or breach of this Contract identified by MDHHS.

B. CAPs may be issued for a first offence for larger or more concerning issues.

C. Contractor must submit a complete and acceptable CAP to MDHHS within 30 Business Days from the date of receipt of MDHHS' CAP notification unless otherwise directed by MDHHS.

D. The CAP gives Contractor the opportunity to analyze and identify the root causes of the identified material deficiency, finding, event, or breach and to develop a plan to address the findings to ensure future compliance with this Contract and state/ and federal regulations.

E. 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.

F. 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.

   c. A specific proposal to cure or resolve the deficiency and plan to avoid future non-compliance of the deficiency.

   d. Contractor must include in its CAP milestone dates for progress and an anticipated date of resolution for the issue. Contractor must provide MDHHS with updates on the dates listed to ensure operational compliance with the CAP as proposed. The implementation of a CAP does not preclude Contractor from the accumulation of non-CAP related violations.

G. Contractor must respond to any and all inquiries and requests for further information by MDHHS. MDHHS may:

   a. Condition the approval on completion of tasks in the order or priority that MDHHS may reasonably prescribe.

b. Disapprove portions of Contractor's proposed CAP.

c. Require additional or different corrective action(s).

H. MDHHS' acceptance of a CAP will not:

a. Excuse Contractor's prior substandard performance.

b. Relieve Contractor of its duty to comply with performance standards.

c. Prohibit MDHHS from assessing additional contract remedies for substandard performance, such as monetary or other Sanctions.

I. Monetary Sanctions will be assessed as outlined below regarding CAP submissions:

a. Late Submission of Initial CAP: $1,000 per calendar Day for each Day a CAP submission is late.

b. Failure to Provide Acceptable Initial CAP: $5,000 for failure to provide a complete and acceptable CAP as prescribed by MDHHS.

c. Non-Compliance with Accepted CAP: $2,500 per calendar Day for each Day Contractor fails to comply with an accepted CAP as required by MDHHS.

15.8 Liquidated Damages and Monetary Sanctions.

A. If Contractor breaches this Contract, MDHHS will be entitled to monetary Sanctions in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. 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, Contractor will be subject to the imposition of liquidated damages or monetary Sanctions.

C. Contractor will be assessed liquidated damages or monetary Sanctions regardless of whether the breach is the fault of Contractor or its subcontractors, agents and/or consultants, provided MDHHS has not materially caused or contributed to the breach.

D. MDHHS retains the right to terminate this Contract, either for convenience or for cause even if liquidated damages, monetary Sanctions or other Sanctions are imposed.

16. Critical Incident Reporting.

16.1 General.

A. Critical Incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of an Enrollee, including Provider Preventable Conditions as defined by the National Quality Forum.

B. Contractor must maintain a Critical Incident Management process that consists of its policies and procedures regarding review and management of Critical Incidents and Adverse Events as defined in the Medicaid Provider Manual.

C. Contractor must participate in efforts by the State to prevent, detect, and remediate Critical Incidents (consistent with assuring beneficiary health and welfare pursuant to 42 C.F.R §§ 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the State for HCBS waiver programs under 42 C.F.R. § 441.302(h).

16.2 Critical Incident Notification.

A. Contractor must ensure that all network providers receive proper education and training on topics, issues, and procedures for identifying, preventing and reporting Critical Incidents including how to identify and report incidents when they occur.

B. Contractor must ensure that beneficiaries, their family (as appropriate), and legal representatives receive education on how to identify and report critical incidents within 90 days of enrollment and at least annually thereafter.

C. Contractor must have policies and procedures for documenting, reporting, investigating, and addressing Critical Incidents and Adverse Events, including responsible parties for performing each activity in accordance with MDHHS requirements.

a. These Critical Incident Management policies and procedures must be reviewed and approved by MDHHS upon request.

b. Within 90 days of contract award Contractor must provide to MDHHS policies and procedures for documenting, reporting, investigating, and addressing Critical Incidents and Adverse Events for review and approval.

c. Contractor must, on a quarterly schedule established by MDHHS, provide a summary of all Critical Incidents and Adverse Events and Contractor's actions taken, including the identification of trends and the outcomes of such action.

D. Contractor must designate a multi-disciplinary committee under the leadership of the Chief Medical Officer (CMO) to review Critical Incidents and Adverse Events as they occur, as well as to review summary reports on a quarterly basis.

E. The committee must order, and monitor needed corrective actions, if the action is remediable and issue protocols designed to guide Providers/practitioners in preventing or providing appropriate responses to commonly experienced events or identified trends warranting opportunities for improvement activities.

17. Program Integrity.

17.1 General

A. The MDHHS Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Michigan HIDE SNP Plans consistent with this Contract and the requirements under 42 CFR 438.608.

B. All requirements in this section of the contract must be supported by Contractor internal policies and procedures to demonstrate implementation and compliance.

C. Late program integrity submissions of any type, including but not limited to Compliance Reviews, corrective action plans (CAPs), and/or audit results, may be subject to contract remedies such as sanctions, penalties, and/or liquidated damages.

17.2 Fraud, Waste, and Abuse.

A. 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:

a. Contractor's Fraud, Waste and Abuse compliance program and plan must include, at a minimum, all the following elements:

   i. 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.

      (a) 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.

      (b) Conflict of Interest – Contractor will uphold high ethical standards and is prohibited from holding or acquiring an interest that would conflict with this Contract. Contractor will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. Any potential conflicts of interest must receive internal, documented approval. Such documentation must be saved in accordance with applicable retention policies.

         A. It is not permissible for the executive level staff or compliance officer of the Contractor to be employed by one of their subcontractors in such a capacity.

      (c) 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.

         A. The written compliance policies and procedures must include, at a minimum, the following elements:

(i) Duties and responsibilities of the compliance officer and Compliance Committees.

(ii) How and when employees will be trained.

(iii) Procedures for how employee reports of non compliance will be handled.

(iv) Guidelines on how the compliance department will interact with internal audit department.

(v) Guidelines on how the compliance department will interact with the legal department.

(vi) Guidelines on how the compliance department will interact with the Human Resources department.

(vii) Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.

(viii) Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.

(ix) Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.

(x) Procedures for the monitoring of compliance in Contractor and subcontractor systems and processes.

(xi) Procedures for the monitoring of potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.

(xii) Procedures for performing an investigation of targets selected for audit, including triage and review processes.

ii. 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.

(a) Contractor must designate a compliance officer whose primary responsibility is to oversee the implementation and maintenance of the compliance program.

(b) 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.

(c) The compliance officer must also report directly to corporate governance on the effectiveness and other operational aspects of the compliance program.

(d) 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.

iii. 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.

(a) Contractor must establish a Regulatory Compliance Committee that will advise the compliance officer and assists in the maintenance of the compliance program.

(b) The compliance officer will remain duty-bound to report on and correct alleged fraud and other misconduct.

(c) The compliance officer must chair the Regulatory Compliance Committee.

(d) The Regulatory Compliance Committee must meet no less than quarterly.

iv. 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.

(a) 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.

A. Contractor must also determine under what circumstances it may be appropriate to train nonemployee agents and contractors.

B. 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.

C. The initial compliance training for new employees must occur within 90 Days of the date of hire.

D. Contractor must provide annual refresher compliance training that highlights compliance program changes or other new developments. The refresher training must re-emphasize Medicaid statutory, regulatory, and contractual requirements and the Contractor's code of conduct.

(b) 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.

v. Effective lines of communication between the Compliance Officer and the Contractor's employees.

(a) Hotline or Other System for Reporting Suspected Non-compliance - Contractor must have mechanisms in place for employees and others to report suspected or actual acts of non-compliance.

(b) To encourage communications, confidentiality and non-retaliation policies must be developed and distributed to all employees.

(c) Contractor must use e-mails, newsletters, suggestion boxes, and other forms of information exchange to maintain open lines of communication.

(d) A separate mechanism, such as a toll-free hotline, must be employed to permit anonymous reporting of non-compliance.

(e) 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.

(f) 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.

(g) 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.

(h) The Compliance Officer must establish, implement, and maintain processes to inform the Contractor's employees of procedure changes, regulatory changes, and contractual changes.

vi. Enforcement of standards through well-publicized disciplinary guidelines.

(a) Consistent Enforcement of Disciplinary Policies – Contractor must maintain written policies that apply appropriate disciplinary sanctions on those officers, managers, supervisors, and employees who fail to comply with the applicable statutory and Medicaid program requirements, and with the Contractor's written standards of conduct. These policies must include not only sanctions for actual non-compliance, but also for failure to detect non-compliance when routine observation or due diligence should have provided adequate clues or put one on notice. In addition, sanctions should be imposed for failure to report actual or suspected non-compliance.

(b) The policies must specify that certain violations, such as intentional misconduct or retaliation against an employee who reports a violation, carry more stringent disciplinary sanctions.

(c) In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.

(d) 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.

(e) 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.

A. 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.

vii. 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.

(a) 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.

A. 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.

(b) 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.

A. 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.

b. 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 17.3 Reporting below for the method and timing of such reporting.

i. Contractor must have the right to recover overpayments directly from Providers for the post payment evaluations initiated and performed by the Contractor.

ii. Treatment of recoveries made by the Contractor or its subcontractors of overpayments to providers [in accordance with 42 CFR 438.608(d)(1)].

(a) When the Contractor or its subcontractors recovers payments to providers:

A. The Contractor may retain the recovered overpayment including those based upon fraud, waste or abuse.

B. The Contractor or its subcontractors must adjust encounter data related to the recovered funds appropriately within CHAMPS within 45 days of exhausting appeal periods for identified overpayments. Reporting of recoveries will occur via monthly, quarterly, and annual submissions to MDHHS-OIG using the corresponding templates provided.

C. In the event the Contractor receives a repayment stemming from an external investigation (State or federal), the Contractor must contact MDHHS-OIG within 30 calendar days to initiate the return of any applicable funds. Any applicable documentation will be requested at such time.

(b) 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.

iii. 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.

iv. Pursuant to 42 CFR438.608(a)(7), the Contractor must promptly refer any potential Fraud that the Contractor identifies.

(a) 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:

A. 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.

B. Share referral via secure File Transfer Process (sFTP) using the Contractor's applicable MDHHS- OIG/AG-HCFD sFTP areas.

C. Cooperate in presenting the fraud referral to the OIG and AG-HCFFD at an agreed upon time and location.

D. 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 must not take any of the following actions unless otherwise instructed by OIG:

(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 findings/overpayment.

(iii) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the findings/overpayment.

(b) 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.

(c) 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 17.3 Reporting of this contract.

(d) 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.

(e) Contractor must refer all potential Enrollee fraud, waste or abuse that the Contractor identifies to MDHHS through https://www.michigan.gov/fraud (File a Complaint - Medicaid Complaint Form) or via a local MDHHS office. In addition, the Contractor must report all fraud, waste and abuse referrals made to MDHHS on their quarterly submission described in Section 17.3 Reporting of this contract.

v. In the event the $5,000 threshold is not met, but there is still a heightened concern of a potential credible allegation of fraud (e.g. beneficiary harm or extenuating circumstances),

the contractor must reach out to discuss the possibility of a referral with their assigned analyst as there can be exceptions that warrant referral.

vi. 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.

vii. 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.

(a) Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

(b) All adjustments must be performed regardless of recovery from the Subcontractor and/or Network Provider.

viii. 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.

(a) Contractor's Network Providers must adhere to the Medicaid Provider Manual.

(b) Contractor's Network Providers must agree that MDHHS-OIG has the authority to conduct post payment evaluations of their claims paid by the Contractor.

(c) 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 24.2 et seq. and MCL 24.3 et seq. for post payment evaluations conducted by MDHHS OIG.

(d) a. – c. requirements must be included in the Contractor's:

A. Provider enrollment agreements, and/or:

B. Provider manual – if the Provider enrollment agreements require Providers to adhere to the Contractor's provider manual.

(e) Prior to initiating a post payment evaluation of a Contractor's Network Provider, MDHHS-OIG will:

A. Review the Contractor's quarterly submission information to determine whether the Contractor:

(i) Performed a post payment evaluation of the Provider in the previous 12-month period, or

(ii) Is currently performing post payment evaluation of the Provider.

B. 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.

C. 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.

D. 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.

(f) If MDHHS-OIG proceeds with a post payment evaluation, MDHHS-OIG will:

A. Limit the scope to dates of service that are at least one year old, and

B. Notify the Contractor in writing and request applicable information from the Contractor. (Applicable information may include, but is not limited to: detailed Contractor post payment evaluation history with the Provider, Contractor communication history with the Provider, signed provider enrollment agreement for the Provider, relevant Contractor policy, etc.) Contractor must provide MDHHS-OIG with the name of an individual that will act as the main Contractor contact for each post payment evaluation. Contractor must provide the requested information within 10 Business Days of MDHHS-OIG request.

(g) Determine if a claim-based audit or a sample/extrapolation post payment evaluation will be performed. If an overpayment is identified:

A. 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.

B. MDHHS will review any additional information submitted by the Provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.2 et seq. and MCL 24.3 et seq.) to both the Contractor and the Provider. The Contractor will be notified if there are any changes to MDHHS-OIG's findings after the appeal period has concluded.

C. The Contractor must not:

(i) Contact the subject of MDHHS-OIG's investigation about any matters related to the investigation,

(ii) Enter into or attempt to negotiate any settlement or agreement regarding MDHHS-OIG's findings/overpayment, or

(iii) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with MDHHS-OIG's findings/overpayment.

(iv) If the Provider does not appeal the final findings, MDHHS-OIG will proceed with recovering overpayments from the Contractor.

(v) If the Provider appeals the final findings, MDHHS-OIG will not initiate recoupment from the Contractor until the appeal is resolved.

(vi) If the Provider appeals the final findings and the appeal is resolved in the State's favor, MDHHS-OIG will proceed with recovering the overpayment from the Contractor.

(h) 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 the State will be recovered from the Contractor via an MDHHS withhold or offset from the next capitation payment or primary push pay to the Contractor.

(i) Contractor is responsible for the recovery of overpayments from their Providers.

(j) Contractor must make all necessary adjustments (i.e., for claim-based findings) to encounter data resulting from MDHHS-OIG post payment evaluations within the encounter data correction timeliness standard outlined in the Encounter Data Submission section of this Contract (Section 3.2.II.D.). Contractor must notify MDHHS-OIG when the adjustments are complete.

A. Failure to comply with the encounter correction timeliness standard will result in Contractor incurring

monetary Sanctions, as outlined in Section 20. Encounter Reporting.

ix. Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

c. 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:

i. Changes in the Enrollee's residence.

ii. The death of an Enrollee.

d. Provision for notification to MDHHS-OIG when it receives information about a change in a network provider's circumstances that may adversely affect the network provider's eligibility to participate in the managed care program, including but not limited to termination from the Contractor or subcontractor's network or temporary suspension or payment suspension initiated by the Contractor or subcontractor. See Section 17.3 Reporting below for method and timing of such reporting.

i. When these actions are taken by the Contractor or subcontractor, the Contractor must promptly report the adverse action to MDHHS-OIG via sFTP using the provider adverse action and exclusion reporting form.

ii. Any questions on whether to report such actions must be promptly presented to MDHHS-OIG for clarification prior to submission.

e. 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.

i. Contractor must have methods for identification, investigation, and referral of suspected Fraud cases (42 CFR 455.13, 455.14, 455.21).

(a) 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.

(b) At a minimum, all allegations within MDHHS-OIG audit referrals to the Contractor must be investigated to either substantiate or refute any and all items within the complaint. In addition, a detailed summary of findings must be produced and include all items outlined in the audit referral. Insufficient investigations and/or summaries will be returned to the Contractor to have additional work performed until all items have been resolved.

(c) Investigations related to MDHHS-OIG audit referrals must be initiated as soon as possible, but no later than 30 calendar days from the date sent by MDHHS-OIG.

(d) Contractor may request a one-time extension in writing (email) to MDHHS-OIG no less than five (5) 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.

(e) Unless MDHHS-OIG has granted a written extension as described above, Contractor may be subject to contract remedies including but not limited to monetary Sanctions.

B. Contractor must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential Fraud, Waste and Abuse activities.

(a) Special Investigations Unit – The Contractor must operate a distinct Fraud, Waste and Abuse Unit, Special Investigations Unit (SIU).

A. 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.

B. Contractor must have at minimum one full-time equivalent (FTE) dedicated to Michigan Medicaid for every 100,000 Michigan Medicaid Enrollees or fraction thereof.

(i) 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.

C. 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.

D. 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.

iii. Contractor, at a minimum, must perform the following verification processes:

(a) 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).

(b) 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.

(c) At a minimum, EOBs must be designed to address requirements found in 42 CFR 455.20 and 433.116.

(d) Contractor must ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types.

(e) The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS.

(f) 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.

(g) Contractor must report all EOB activities performed within the previous quarter to MDHHS-OIG. See Section 17.3. Reporting for the method and timing of such reporting.

iv. 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.

(a) Methods may include, but are not limited to, 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 17.3 Reporting of this Contract for the method and timing of such reporting.

v. 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 17.3 Reporting of this Contract for the method and timing of such reporting. All confirmed or suspected provider Fraud must immediately be reported to MDHHS-OIG.

(a) Unless prior written approval is obtained from MDHHS-OIG, Contractor must not take any of the following actions on a potential credible allegation of fraud as they specifically relate to Michigan Medicaid claims:

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 incident.

C. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

vi. Audit Requirements – Contractor must conduct risk-based auditing and monitoring activities of provider transactions, including but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste or Abuse. These audits must include a retrospective medical and coding review on the relevant claims.

(a) Any tips or grievances received by the Contractor must be triaged or otherwise addressed within 30 calendar days from the date of the complaint. Any resulting investigations must be initiated within 30 calendar days of the initial triage.

(b) 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 17.3 Reporting of this Contract for the method and timing of such reporting.

vii. 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 17.3 Reporting of this Contract for the method and timing of such reporting.

f. Provision for written policies for all employees of the Contactor, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

   i. Contractor must include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

g. 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.

h. Contractor must adjust all associated encounter claims identified when authorized by MDHHS-OIG for overpayment recoupment within encounter data timeliness standard outlined in this Contract including but not limited to the Encounter Data Submission section of this Contract (Section 20). Encounter Reporting). Contractor's failure to comply with the encounter correction timeliness standard will result in Contractor incurring monetary Sanctions as outlined in Appendix L 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, Contractor may be subject to other contract remedies.

i. 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:

i. Fraud hotline complaints; g. Claims data mining, or

ii. Patterns identified through provider audits, civil false claims cases and law enforcement investigations.

iii. 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.

j. Provision for the Contractor to include available methods (e.g., tollfree 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.

17.3 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 O for the listing of notification forms and reports and their respective due dates. If Compliance Review submissions are not submitted on or before the designated due date, Contractor will receive a score of "Not Met" and may be subject to contract remedies including but not limited to sanctions, penalties, and/or liquidated damages.

A. On a monthly basis, the Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing all overpayments identified, recovered, and adjusted within the previous month (42 CFR 438.608(a)(2).

B. 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 17.3 Reporting of this Contract, during the previous quarter. This report must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Contractor during the course of its program integrity activities. It is understood that identified overpayments may not be recovered during the same reporting time period. This report also includes a list of the individual

encounters corrected. To ensure accuracy of reported adjustments, Contractor must:

a. Purchase at minimum one license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the case management system and to check the completeness and accuracy of report submissions.

b. For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid must be voided and resubmitted with zero dollars paid.

c. Specify overpayment amounts determined via sample and extrapolation, rather than claim-based review. In instances where extrapolation occurs there are no encounters to correct.

d. Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.

    i. These encounters must be identified by the Contractor and reported to MDHHS- OIG. MDHHS-OIG will record a gross adjustment to be taken out of the Contractor's next capitation payment.

e. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

    i. Contractor must adjust all associated encounters identified by MDHHS-OIG for overpayment recoupment within encounter data timeliness standard outlined in this Contract including but not limited to the Encounter Data Submission section of this Contract Section 20. Encounter Reporting.

    ii. Contractor failure to comply with the encounter correction timeliness standard will result in Contractor monetary Sanction as outlined in Appendix L, corrective action and may result in a gross adjustment for the determined overpayment amount to be taken from Contractor. In addition to the determined overpayment amount being withheld via gross adjustment, the Contractor may be subject to other contract remedies.

iii. Contractor will not be subject to monetary Sanctions for identified encounters that are no longer available and accessible in CHAMPS.

C. 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.

D. Pursuant to 42 CFR 438.608(d)(3), on an annual basis, Contractor must submit to MDHHS- OIG, in a format determined by MDHHS-OIG, an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report also must address the Contractor's plan of activities for the current and upcoming fiscal year. The report must include all provider and service-specific program integrity activities. The report must include an attestation confirming compliance with the requirements found in 42 CFR § 438.608 and 42 CFR § 438.610.

   a. 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.

E. Any excluded individuals and entities discovered in the screening described in subsection 17.8 of this contract below, 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.

F. 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.

G. 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.

H. Contract Compliance Review Score – Contractor will be scored based on the quantity and quality of the quarterly reports submitted to MDHHS-OIG.

   a. Contractor will receive a score of Met if they initiated program integrity activities as required by Section 17.3 Reporting during the reporting period, complied with the MDHHS-OIG quarterly submission form content requirements and accompanying guidance document, and complied with deliverable due dates.

   b. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not initiated any program integrity activities, as required by Section 17.3 Reporting of this Contract, during the previous quarter.

   c. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not complied with the MDHHS-OIG quarterly submission form content requirements and/or the accompanying guidance document.

   d. Contractor will receive a score of Not Met for any Contract compliance review quarter where it has not complied with the deliverable due dates.

17.4 Availability of Records – Contractor must cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation must include providing, upon request, information, access to records and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation. The Contractor must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

A. 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 17 of this Contract.

B. 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).

C. Contractor and its subcontractors and any providers of service, including but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438.5(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 medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records must be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and 10 years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

D. 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.

17.5 Provider Manual and Bulletins – Contractor must issue Provider Manual and Bulletins or other means of Provider communication to the providers of medical, mental, dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all Contract requirements are being met. The Contractor may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

A. The Contractor's provider manual must provide all of its Providers with, at a minimum, the following information:

   a. Description of the Michigan Medicaid managed care program and covered populations.

   b. Scope of Benefits.

   c. Covered Services.

   d. Emergency services responsibilities.

   e. Grievance/appeal procedures for both Enrollee and provider.

   f. Medical necessity standards and clinical practice guidelines.

   g. The Contractor's policies and procedures including, at a minimum, the following information:

      i. Policies regarding provider enrollment and participation.

      ii. Policies detailing coverage and limits for all covered services.

      iii. Policies and instructions for billing and reimbursement for all covered services.

      iv. Policies regarding record retention.

      v. Policies regarding Fraud, Waste and Abuse;

      vi. Policies and instructions regarding how to verify beneficiary eligibility.

   h. Primary Care Physician responsibilities.

   i. Requirements regarding background checks.

   j. Other provider/subcontractors' responsibilities.

   k. Prior authorization and referral procedures.\

   l. Claims submission protocols and standards, including instructions and all information necessary for a clean claim.

   m. Medical records standards.

   n. Payment policies.

   o. Enrollee rights and responsibilities.

   p. Self-reporting mechanisms and polices as cited in Section 17.3 Reporting.

B. 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.

C. Contractor must submit Provider Manual, Bulletin and or other means of Provider communications to MDHHS-OIG upon request.

17.6 Provider Agreements - Contractor must submit its Provider Agreements to MDHHS-OIG upon request.

17.7 Affiliations with Debarred or Suspended Persons – Pursuant to 42 CFR 438.610.

A. Contractor must not knowingly have a director, officer, partner, managing employee or person with beneficial ownership of more than 5% of the Contractor's equity who has been or currently debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order 12549 of Feb. 18, 1986, (51 FR 6370, 3 CFR, 1986 Comp., p. 189,) or under guidelines implementing such order.

B. 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.

C. 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 or suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order.

D. Contractor must provide written disclosure of any director, officer, partner, managing employee, person with beneficial ownership of

more than 5% of the Contractor's equity, Network Provider, subcontractor, or person with employment, consulting, or any other contractual agreement who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order; and any individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Act.

E. If MDHHS learns that the Contractor has a prohibited relationship as described above and provided by Federal Acquisition Regulation, Executive Order No. 12549, or under Section 1128 or 1128A of the Act, MDHHS may continue an existing agreement with the Contractor unless CMS directs otherwise. MDHHS may not renew or otherwise extend the duration of an existing agreement with the Contractor unless CMS provides to MDHHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite prohibited affiliations.

F. 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.

   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.

G. 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 17.8. Disclosure by Managed Care Entities of this Contract.

17.8 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.

A. 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.

B. 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.

C. 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.

D. 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.

E. All required disclosures under this subsection must be made to MDHHS, the Secretary of the US Department of Health and Human Services and the Inspector General of the US Department of Health and Human Services in the format developed by the requestor. Failure to provide required information may lead to Sanctions, including but not limited to withholding of capitation payment. Federal financial participation is not available for entities that do not comply with disclosures, therefore, MDHHS may withhold capitation

from the Contractor for services provided during the period beginning on the Day following the date the information was due and ending on the Day before the date on which the information was supplied.

17.9 Excluded Individuals and Entities – Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person. (Section 1903(i)(2) of the Social Security Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b)). Contractor must monitor its Network Providers for excluded individuals and entities by requiring its Network Providers be actively enrolled with the Michigan Medicaid Program.

A. 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.

B. Contractor is prohibited from entering into any employment, contractual and control relationships with any excluded individual or entity.

C. Monetary Sanctions may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (Section 1128A(a)(6) of the Social Security Act).

D. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5% or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (Section 1126(b) of the Social Security Act, 42 CFR 455.104(a), and 42 CFR 1001.1001(a)(1)).

E. Contractor must immediately terminate all beneficial, employment, and contractual and control relationships with any individual or entity excluded from participation by MDHHS.

F. When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for a credible allegation of fraud under 42 CFR 455.23, Contractor must, at minimum, apply

the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, Contractor may elect to do the same.

18. Network Provider Medicaid Enrollment

18.1 Pursuant to 42 CFR 438.602(b)(1), all Network Providers of the Contractor must enroll with the Michigan Medicaid Program.

A. The State will screen and enroll, and periodically revalidate all enrolled Medicaid providers.

B. Contractor must require all its Network Providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.

a. Contractor may execute Network Provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 Days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled or the expiration of one 120-Day period without enrollment of the provider, and notify affected enrollees.

C. Contractor must verify and monitor its Network Providers' Medicaid enrollment by reviewing a Weekly CHAMPS Provider Enrollment File (5938) Exchange to be provided by MDHHS.

19. Data Submissions, Reporting Requirements, and Survey.

19.1 General Requirements for Data.

A. Contractor must provide and require its First Tier, Downstream, and Related Entities to provide:

a. All information MDHHS requires under the Contract related to the performance of Contractor's responsibilities, including non-medical information for the purposes of research and evaluation.

b. Any information MDHHS requires to comply with all applicable federal or State laws and regulations.

c. Any information MDHHS requires for external rapid cycle evaluation including and not limited to program expenditures, service utilization rates, rebalancing from institutional to

community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and Enrollment/disenrollment rates.

19.2 General Requirements for Reporting.

A. Contractor must:

a. Submit to MDHHS applicable MDHHS reporting requirements in compliance with this Contract.

b. Submit to MDHHS and CMS as applicable, Medicaid reporting requirements in compliance with 42 C.F.R. § 438 et seq., including but not limited to audited financial reports as required by 42 CFR §438.3(m) as it may be amended from time to time.

c. Submit to MDHHS all required reports and data in accordance with the specifications, templates and time frames described in this Contract.

d. Report HEDIS, HOS, and CAHPS data, as well as measures related to Long Term Supports and Services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements, plus additional Medicaid measures required by MDHHS.

e. Contractor must contract with an NCQA certified HEDIS vendor and undergo a full audit of its HEDIS reporting process.

f. Contractor must directly contract with an NCQA certified CAHPS vendor and submit the data according to the specifications established by NCQA.

g. Upon request, submit to MDHHS any internal reports that Contractor uses for internal management. Such reports must include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance.

h. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements requested by MDHHS on Provider Preventable Conditions in the form and frequency specified by MDHHS.

i. Upon request, provide to MDHHS, in a form and format approved by MDHHS and in accordance with the timeframes established by MDHHS, all reports, data or other information MDHHS determines are necessary for compliance with provisions of the

Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations.

j. Submit at the request of MDHHS additional ad hoc or periodic reports or analyses of data related to the Contract.

B. Data, documentation, or information Contractor submits to the State must be certified by either Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign so the CEO or CFO is ultimately responsible for the certification.

C. The certification, pursuant to 42 CFR 438.604(a), 438.606, and 438.608(d)(3), must be submitted concurrently with the submission of data and must attest that, based on best information, knowledge, and belief, the data are accurate, complete, and truthful.

19.3 Reporting Requirements.

A. Currently reported quality assessment data and deliverables required for Medicare Advantage plans to be received within thirty (30) business days of submission or receipt—which includes but is not limited to:

a. Audited summary-level and patient-level Healthcare Effectiveness Data and Information Set (HEDIS) data Contractor is required to submit to National Committee for Quality Assurance (NCQA) and CMS respectively;

i. The final NCQA HEDIS Compliance Audit Report provided to Contractor by the NCQA licensed audit firm;

ii. All Medicare Health Outcomes Survey (HOS) data feedback reports provided to Contractor by CMS; and

iii. Any reports or materials pertaining to annual Contractor participation in the Medicare Advantage and Prescription Drug Plan (MA & PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

b. Significant changes to the terms of the Medicare contract with CMS, including D-SNP non-renewals, terminations, and service area reductions within fifteen (15) business days of approval by CMS.

c. Audit findings and corrective action plans, within fifteen (15) business days of either being notified by CMS or submitting them to CMS.

d. Any changes made to the use of projected Medicare savings and rebates within fifteen (15) business days of CMS approval of the changes.

e. Notices of non-compliance from CMS within fifteen (15) business days of the notification.

f. Sanctions of any kind imposed by CMS within fifteen (15) business days of the notification.

g. Performance information, including CMS warning letters, deficiency notices, and notices of Medicare star ratings less than 3.0, within fifteen (15) business days of the notification.

20. Encounter Reporting.

20.1 Encounter Data Submission.

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

a. Companion Guides/Data Clarification Documents.

b. Electronic File Layout Instructions.

c. Encounter reporting presentations.

d. Any additional MDHHS guidance made available to Contractor relating to Encounter Data submission. Encounter Data reporting requirements must be posted to MDHHS' website:

https://www.michigan.gov/en/mdhhs/doing-business/providers/hipaa/hipaa-companion-guides

B. Contractor encounter submissions must be certified by an authorized agent of Contractor in accordance with 42 CFR 438.606.

C. Contractor must submit pharmacy Claims data, including required data elements and modifiers, in accordance with MDHHS Pharmacy 340B policy and claim submission requirements.

D. Contractor must ensure that all submitted encounter data is timely, accurate and complete.

a. Within seven Days of the original submission attempt, Contractor must correct and resubmit files that fail to load in their entirety.

b. MDHHS will deem encounter data submitted when it is accepted, certified and processed in MDHHS systems.

c. 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.

d. When adjustments or voids are made to original encounter claims, Contractor must submit these adjustments or voids appropriately so that the correct final adjudication of the claim reflects on the encounter.

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

   i. 837 HIPAA format for all non-pharmacy Claims (professional, institutional and dental).

   ii. Post Adjudicated NCPDP v 4.2 format for all pharmacy Claims.

   iii. Prescription Drug Event (PDE) for Medicare Part D covered prescriptions. MDHHS aligns with the CMS PDE outbound file layout effective 1/1/2026, and as that file layout may be changed from time to time.

f. Timely and complete encounter data submission must be made by the 15th of the month for all encounters adjudicated in the previous month while meeting minimum volume requirements. (e.g. All encounters adjudicated in April must be submitted by May 15th and all encounters adjudicated in May must be submitted by June 15th.)

g. If at any time Contractor determines Encounter Data is not complete and accurate, Contractor must:

   i. Notify MDHHS prior to Encounter Data Submission that the data is not complete or accurate.

   ii. Provide MDHHS a corrective action plan within 30 calendar days of identifying the Encounter Data is not complete or accurate, that details steps for resolution including

improvements and enhancements to bring the Encounter Data into compliance.

iii. Implement approved corrective action plan within 30 calendar days of submitting the plan to MDHHS for review and approval.

iv. Upon request, participate in a validation study performed by MDHHS or its designee following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The HIDE SNP may be financially liable for such validation study.

h. Encounter File transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS. The rate will be calculated monthly for each encounter type and shared with Contractor. Contractor failure to comply with the encounter acceptance rate standard may result in contract remedies including but not limited to monetary Sanctions and other Sanctions.

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

i. Biannually, Contractor will complete an Encounter Comparison Process which will compare the accepted claims/encounters in Contractor's system to the accepted encounters in the MDHHS data warehouse by invoice type. Contractor failure to achieve a percentage of 98% or greater for each calculation, may be subject to contract remedies including but not limited to monetary Sanctions and other Sanctions.

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

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

(a) 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.

(a) 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%.

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

l. Contractor will be held responsible for errors or non-compliance resulting from their own actions or the actions of an agent authorized to act on their behalf. Subcontracted encounter data must comply with all MDHHS requirements and specifications.

m. Stored Encounter Data will be subject to regular and ongoing quality checks as developed by MDHHS. MDHHS will give 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. Contractor's submission of Encounter Data must meet timeliness and completeness requirements as specified by MDHHS. Contractor must participate in regular data quality assessments conducted as a component of ongoing Encounter Data on- site activity.

n. 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.

i. Contractor must make all necessary adjustments to encounter data resulting from MDHHS reviews including

but not limited to quality, accuracy, program integrity and validation checks. All adjustments must be completed and resubmitted to MDHHS in accordance with the Encounter correction timeliness standard established by MDHHS. Contractor must notify MDHHS when the adjustments are resubmitted.

Number of Transaction Control Numbers (TCNs) to be Corrected and/or Resubmitted (Does not include any corresponding voids for resubmissions)	**Number of Days After the Request is Made by MDHHS That Those Encounters Must Be Submitted to and Accepted by CHAMPS**
5,000 or less	45 Days
Greater than 5,000	60 Days

o. Failure of Contractor to submit encounter data and resubmissions in accordance with MDHHS timeliness standard may result in contract remedies including but not limited to monetary Sanction and other Sanctions in accordance with contract standards.

p. MDHHS may consider approval of extended timeframes for encounter data submission and resubmission on a case by case basis per Contractor's written request which must include an extenuating reason for such a request and estimated date of completion.

i. 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.

ii. Excessive extension requests will be considered Contractor noncompliant performance and MDHHS may pursue contract remedies including but not limited to monetary Sanction and other Sanctions in accordance with contract standards.

E. Encounter Data Quality Standards.

a. MDHHS will review for and validate all submitted encounter data for completeness and accuracy.

b. 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.

c. Contractor must submit encounter data for enrollee health services that 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 Contractor.

d. MDHHS or its designee may investigate encounter data quality issues including but not limited to:

    i. Utilization.

    ii. Service date lag time benchmarks.

    iii. Expected EDI fail amounts.

    iv. Average paid amount per service, by billing code.

    v. Application of National Correct Coding Initiatives edits.

    vi. Compliance with benefit and processing rules detailed in the Michigan Medicaid Provider manual, as appropriate.

    vii. Payment for duplicate services.

e. Contractor must collect and maintain one-hundred percent (100%) encounter data for each covered service and supplemental benefit services provided to Enrollees, including encounter data from any sub-capitated sources.

f. Contractor must evaluate the completeness and quality of its subcontractor encounter data and keep record of its procedures and evaluations. Records must be made available upon MDHHS request.

g. 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.

h. Contractor must cooperate and comply with any audit arranged for by MDHHS to determine accuracy, truthfulness, and completeness of submitted encounter data.

i. Contractor must provide medical records of Enrollees and a report from administrative databases of the Encounter Data of such Enrollees in order to conduct validation assessments upon request. Such validation assessments may be conducted annually.

j. Contractor must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MDHHS' data quality standards.

k. Beginning in contract year two (2), the contractor's Total/Composite Paid Amount Variances must be within +/- 5%. The calculation for the variance is calculated from the totaled Paid Amounts reported in the Appendix A Financial Data Request and the EQI Encounter datasets and published the DRIVE Tool. The calculation is as follows:

([Total Plan Reported Paid Amount] – [Total Paid Amount from EQI Encounters]) / [Total Paid Amount from EQI Encounters]

20.2 Contractor must participate in MDHHS' Encounter Quality Initiative.

A. Contractor must:

a. Attend and participate in all MDHHS scheduled monthly quality phone meetings. Submit timely completed EQI data template requests and Appendices, in accordance with the Encounter Quality Initiative Schedule.

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

c. Acquire and maintain access to any required software applications or tool needed to complete the EQI reconciliation report.

i. Each Contractor must maintain an active license for the Dashboard for Research, Insight, and Validation of Experience (DRIVE™) tool, licensed by MDHHS vendor, Milliman.

B. Contractor failure to participate in MDHHS encounter quality reviews in accordance with MDHHS standards may entitle MDHHS to pursue contract remedies including but not limited to monetary Sanction and other Sanctions.

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

C. Contractor must submit applicable SDOH diagnosis codes (z codes) on Encounters including specific reimbursement amounts and frequencies.

D. Contractor must include a diagnosis code on Encounters for Personal Care Services.

E. For ICD-9, Contractor must use diagnosis code V60.89 (Other specified housing or economic circumstances) or V60.4 (No other household member able to render care) unless another diagnosis code is deemed more appropriate for the unique circumstances of the Enrollee.

F. For ICD-10, Contractor must use diagnosis code Z74.1 (Need assistance with personal care) or Z74.2 (No other household member able to render care) unless another diagnosis code is deemed more appropriate for the unique circumstances of the Enrollee.

20.3 If Contractor does not already submit Medicare or Medicaid encounter data to MDHHS, Contractor must engage MDHHS no later than one hundred twenty (120) days prior to January 1 of the contract year to establish a project plan and timeliness for submitting to MDHHS all encounter data required under this section.

20.2 Contractor and MDHHS must make good faith efforts to operationalize the project plan and to demonstrate readiness to submit encounter data files no later than one hundred and eighty days (180) after January 1 of the contract year. Contractor must submit all historical encounters dating back to January 1 of the contract year to resolve the project plan. MDHHS will provide technical assistance to Contractor to support implementation of the project plan.

21 Direct Capitation Payment for Covered Medicaid Services.

21.1 General.

A. The contractor will receive direct capitation from the State Medicaid Agency to cover Medicaid benefits.

B. MDHHS will generate HIPAA-compliant 834 files that will be sent to Contractor prior to month's end identifying expected enrollment for the following service month.

C. At the beginning of the service month, MDHHS will automatically generate invoices based on actual Enrollee enrollment and in accordance with the capitated monthly rates calculated as summarized in Exhibit 4.1 below.

D. Contractor will receive one lump-sum payment approximately at mid-service month as full compensation for Michigan Medicaid goods and services provided hereunder in that month.

E. MDHHS will report payments to Contractor on a HIPAA-compliant 820 file.

F. A process will be in place to ensure timely payments and to identify Enrollees Contractor was responsible for during the month but for which no payment was received in the service month.

G. MDHHS may initiate a process to recoup Capitation Payments made to Contractor for Enrollees who were retroactively disenrolled.

Exhibit 4.1 – Summary of Medicaid Rate Cell Categories.

Rating Category / Rate Cell	**Description**
Tier 1	Enrollees who on the first day of the month, (1) meet the Nursing Facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (LOCD) tool, and (2) occupy a Nursing Facility bed certified for both Medicare and Medicaid. Rates may vary by age. Rates will vary for the four contracting regions. Separate rates will be paid for publicly owned and privately owned Nursing Facilities

Rating Category / Rate Cell	Description
Tier 2	Enrollees who on the first day of the month, (1) meet the Nursing Facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (LOCD) tool, (2) live in any setting other than that referenced in Tier 1, and (3) are enrolled in the MICH HCBS waiver. Rates may vary by age. Rates will vary for the four contracting regions
Tier 3	Enrollees who do not meet the criteria for Tier 1 or Tier 2 on the first day of the month. Rates may vary by age. Rates will vary for the four contracting regions

21.2 Dispute Resolution.

A. Duty to Negotiate in Good Faith.

a. In addition to the provisions set forth in the Standard Contract Terms, 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 must 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 must 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 Contract as noted above, the parties may agree to a neutral third-party alternate dispute resolution including mediation and/or arbitration.

22 Training.

22.1 Contractor must implement an evidence-based, comprehensive diversity, equity, and inclusion (DEI) assessment and training program for the organization. The program must assess all organizational personnel, policies, and practices. Contractor must conduct at least one implicit bias training annually as part of their DEI program and ensure that all Contractor employees who interact with Enrollees

receive implicit bias training. The program must include additional facets of diversity, equity, and inclusion in addition to implicit bias.

22.2 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.

22.3 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.

23 Specific Standards.

23.1 IT Policies, Standards and Procedures (PSP) Contractors are advised that the State has methods, policies, standards and procedures that have been developed over the years. Contractors are expected to conform to State IT policies and standards. All services and products provided as a result of this Contract must comply with all applicable State IT policies and standards. Contractor is required to review all applicable links provided below and state compliance for the publicly available PSP's in their response. Non-public State PSP's are available to Contractors under NDA.

A. Public IT Policies, Standards and Procedures (PSP).

B. DTMB - IT Policies, Standards & Procedures (michigan.gov).

23.2 Acceptable Use Policy. To the extent that Contractor has access to the State's computer system, Contractor must comply with the State's Acceptable Use Policy, see 1340.00.130.02 Acceptable Use of Information Technology (michigan.gov). All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State's system. The State reserves the right to terminate Contractor's access to the State's system if a violation occurs.

23.3 SOM Digital Standards. All software items provided by the Contractor must adhere to the State of Michigan Application/Site Standards which can be found at www.michigan.gov/standards.

23.4 Mobile Responsiveness. The Contractor's Software must utilize responsive design practices to ensure the application is accessible via a mobile device.

23.5 ADA Compliance. The State is required to comply with the Americans with Disabilities Act of 1990 (ADA) and has adopted standards and procedures regarding accessibility requirements for websites and software applications. All websites, applications, software, and associated content and documentation provided by the Contractor as part of the Solution must comply with the Digital Accessibility Standards.

23.6 User Type and Capacity. Contractor must be able to meet the expected number of concurrent users of any offered online system based on the total number of enrolled members across the State.

23.7 End-User Operating Environment.

A. The SOM IT environment includes FedRAMP authorized major cloud providers and on-premises market leading virtualization environments, with supporting platforms that includes enterprise storage, monitoring, and management running in house and in cloud hosting provides.

B. Contractor must accommodate the latest browser versions (including mobile browsers) as well as some pre-existing browsers. To ensure that users are able to access online services, Contractor must ensure applications and websites display and function accurately in, at minimum, the two most recent major versions of the following browsers, without reliance on special plugins or extensions:

   a. Google Chrome.

   b. Microsoft Edge.

   c. Firefox.

   d. Safari.

C. Contractor must support the current and future State standard environment at no additional cost to the State.

23.8 Enrollee and Provider Website(s) or Web Portal. The contractor will maintain an public website, secure Enrollee portal, and Provider portal.

23.9 Migration. The Contractor will communicate any migration process to the State and ensure all configurations, policies, and encryption standards are replicated in the new environment.

23.10 Contract Activities and Hosted Services. Contractor must maintain and operate a business continuity and disaster recovery plan in accordance with the requirements set forth in this Contract.

23.11 Staffing.

A. `Contractor Representative.

a. The Contractor must appoint individuals specifically assigned to State of Michigan accounts, who will respond to State inquiries regarding the Contract Activities, answer questions related to ordering and delivery, etc. (the "Contractor Representative"). Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 48 hours. Refer to Schedule A - Section 34 Personnel for a list of all required Personnel.

b. The Contractor must notify the Contract Administrator at least 5 calendar days before removing or assigning a new Contractor Representative.

State:	Contractor:

B. 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:

C. 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:

D. Customer Service Number. The Contractor must specify its number for the State to contact the Contractor Representative. The Contractor Representative must be available for calls during the hours of 8:00 am to 5:00 pm EST.

Customer Service Number:

E. Personnel.

a. The Contractor must appoint individuals who will be directly responsible for the day-to-day operations of the Contract ("Personnel"). Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquiries within 48 hours.

b. Contractor will notify the State of the proposed assignment or replacement of any Personnel within 48 hours of the assignment or replacement and provide contact information for the new Personnel. The State may request a resume and other reasonable information about newly appointed individuals. The State may request an interview of the newly appointed individual. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection. The State may require a 30-calendar day training period for replacement personnel.

c. Administrative Personnel Requirements.

i. Care Management Director

ii. Compliance Officer

iii. LTSS Director

iv. ADA Compliance Director

v. Chief Financial Officer (CFO)

vi. Executive Director/Chief Executive Officer (CEO)

vii. Grievance and Appeals Coordinator

viii. HIDE SNP Program Medicaid Liaison

ix. Management Information System Director

x. Medical Director

xi. Member Services Director

xii. Pharmacy Director

xiii. Population Health Management Director

xiv. Privacy Officer

xv. Provider Services Director

xvi. Quality Improvement and Utilization Director

xvii. Security Officer

xviii. SIU Manager/Liaison

d. Contractor must inform MDHHS in writing within 7 business days of vacancies or staffing changes for the personnel listed above in i - xviii of this Section.

e. Contractor must fill vacancies for the personnel listed above in I - xviii of this section with qualified persons within six months of the vacancy unless an extension is granted by MDHHS.

f. Contractor must inform MDHHS in writing within 14 business days of vacancies or staffing changes for the following personnel:

i. Care Management Director

ii. Compliance Officer

iii. Grievance and Appeals Coordinator

iv. HIDE SNP Program Medicaid Liaison

v. Management Information System Director

vi. Provider Services Director

g. For Medicaid Liaison vacancies, Contractor must inform MDHHS in writing of acting or permanent replacement within 3 business days of the vacancy.

h. Contractor must ensure that all staff has appropriate training, education, experience, licensure as appropriate and liability coverage to fulfill the requirements of the positions.

i. Contractor must employ or contract with sufficient, clinically qualified administrative staff to perform utilization activities for dental services required in this Contract.

j. Contractor must ensure that all requested and/or appropriate personnel attend or are made available during MDHHS onsite visitations with Contractor.

F. Administrative Personnel Responsibilities.

a. Executive Director/Chief Executive Officer (CEO).

i. Full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract.

ii. Oversight of budget and accounting systems.

iii. Responsibility to the governing body for daily operations.

b. Medical Director.

i. Michigan-licensed physician (MD or DO).

ii. Responsible for all major clinical program components of the Contractor.

iii. Responsibility to review medical care provided to Enrollees and medical aspects of Provider Contracts.

iv. Ensure timely medical decisions, including after-hours consultation as needed.

v. Management of the Contractor's Quality Assessment and Performance Improvement Program (QAPI).

vi. Must ensure compliance with State and local reporting laws on communicable diseases, child Abuse, and neglect.

vii. Must coordinate with the Population Health Management Director and provide clinical leadership on population health.

c. Pharmacy Director.

i. Responsible for the performance of all pharmacy program components of the Contractor.

ii. Responsible for oversight and Contract compliance of all pharmacy program related subcontractors (i.e. Pharmacy Benefit Managers).

iii. Ensures timely pharmacy prior authorization review, processing, and claim overrides, including after-hours reviews, as warranted.

iv. Ensures compliance with Federal and State laws, regulations, and reporting requirements that are applicable to the pharmacy program.

v. Full-time administrator who possesses the training and education necessary to meet the requirements for pharmacy director as required in the Contract. The Pharmacy Director may be any of the following:

(a) Michigan licensed pharmacist.

(b) Michigan licensed certified pharmacy technician.

(c) Other licensed clinician as approved by MDHHS.

(d) Other professional possessing appropriate credentials and experience as approved by MDHHS.

d. Quality Improvement and Utilization Director.

i. 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:

(a) Michigan licensed physician.

(b) Michigan licensed registered nurse.

(c) Certified professional in health care quality.

(d) Other licensed clinician as approved by MDHHS.

(e) Other professional possessing appropriate credentials as approved by MDHHS.

ii. Must provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed, including but not limited to:

(a) Ensure the Contractor collects and meaningfully uses demographic and geographic data (e.g., race, ethnicity, language, disability, sexual orientation, gender identity) to identify disparities.

(b) Develop targeted interventions designed to reduce health disparities and address health inequities.

(c) Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to reduce health disparities and address health inequities.

(d) Collaborate with the Contractor's Population Health Management Director to ensure health equity is advanced in the context of the Contractor's population health initiatives.

iii. 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.

e. Chief Financial Officer.

i. Full-time administrator responsible for overseeing the budget and accounting systems.

f. Population Health Management Director.

i. Master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field.

ii. Responsible for all population health management components for the Contractor.

iii. Oversee the Contractor's strategic design and implementation, of population health initiatives based on a

deep understanding of scientific population health principles. Evaluation of the population health initiatives may be the responsibility of the Population Health Management Director or the Quality Improvement and Utilization Director.

iv. Sponsor and champion Contractor and system-wide initiatives, including cultivating the support necessary to achieve the desired objectives of supporting equitable whole person care for Enrollees.

v. Develop and implement operational plans that address the market opportunities/challenges and align with the established population health goals of serving the whole person, including Enrollees' medical and non-medical needs.

vi. Must coordinate with the Medical Director and the Quality Improvement and Utilization Director and external parties on population health activities.

g. LTSS Director.

i. Master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field.

ii. Develop and implement operational plans to improve LTSS access and service utilization.

iii. Must coordinate with the Medical Director, Quality Improvement and Utilization Director, Care Management Director and Population Health Management Director.

h. Care Management Director.

i. Master's degree or other advanced degree in nursing, social work, health services research, health policy, information technology, or other relevant field.

ii. Direct health plan care management and care coordination functions, including person centered planning and coordination with external entities, such as community organizations and other payers.

iii. Must coordinate with the Medical Director, Quality Improvement and Utilization Director, LTSS Director and Population Health Management Director.

i. Management Information System Director.

   i. 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 and encounters.

j. Compliance Officer

   i. Full-time administrator to oversee the Contractor's compliance with the terms of this Contract, including but not limited to the Contractor's compliance plan and reporting of Fraud, Waste and Abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

k. Member Services Director.

   i. Coordination of communications with Enrollees and other Enrollee services such as acting as an Enrollee advocate. Ensure sufficient member services staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

l. Provider Services Director.

   i. Coordination of communications with Subcontractors and other providers.

   ii. Ensure sufficient provider services staff to enable Providers to receive prompt resolution of their problems or inquiries.

m. Grievance/Appeal Coordinator.

   i. Coordination, management, and adjudication of Enrollee and Provider Grievances.

n. Security Officer.

   i. Development and implementation of security policies and procedures outlined in 45 CFR 164.

   ii. Designated as the individual to receive complaints pursuant to security breaches in the Contractor's or State's policies and procedures.

o. Privacy Officer.

   i. Development and implementation of privacy policies and procedures outlined in 45 CFR 164.

ii. Designated as the individual to receive complaints pursuant to breaches of the Contractor's privacy policies and procedures.

p. Designated Liaisons.

i. HIDE SNP Program Medicaid Liaison.

ii. SIU manager or liaison.

q. Support/Administrative Staff.

i. Contractor must have adequate clerical and support staff to ensure that the Contractor's operation functions in accordance with all Contract requirements.

r. ADA Compliance Director or point of contact for reasonable accommodations.

i. Responsible for assuring meaningful compliance with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

ii. Otherwise responsible for meeting all other requirements stated in this contract regarding applicable legal non-discrimination requirements, such as provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations.

iii. Responsible for collection of sufficient information from providers to assess compliance with the ADA, including conducting required surveys and or site reviews of facilities for both physical and programmatic accessibility.

s. One person may hold more than one position described above, so long as the duties of each position are consistently met. The Contractor must provide title(s), address and contact information for each person acting as Personnel.

23.12 Organizational Structure.

A. Contractor Administrative Linkages. Contractor's management approach and organizational structure must ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality

improvement and utilization review, Grievance/Appeal review, and management information systems.

B. Contractor Administrative Practices. Contractor must be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. Contractor must employ senior level managers with experience and expertise in health care management and must employ or contract with skilled clinicians for medical management activities.

C. Financial Interest for Contractor Employees. Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its Provider Network or in the conduct of the Contractor's affairs. Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes managing employees, all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

D. Disclosure of Financial Interest for Contractor Employees.

   a. Providers – all contracted Providers.

   b. Provider employees – directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity.

   c. 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. In accordance with 42 CFR 438.602(i) and Medicaid policy, Contractor's business must be located within the United States. Contractor's failure to meet this requirement is cause for termination as described in the Standard Contract Terms.

23.13 Governing Body.

A. Contractor Governing Body. Contractor must have a governing body to ensure adoption and implementation of written policies governing the operation of the Contractor.

B. Governing Body Chair. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body.

C. Governing Body Meetings. The governing body must meet at least quarterly and must keep a permanent record of all proceedings available to MDHHS and/or CMS upon request.

D. Governing Body Membership.

a. Health maintenance organization's governing body must include no less than 1 individual who represents the health maintenance organization's membership.

b. Pursuant to MCL 500.3511, a Health Maintenance Organization that is under a contract with this state to provide medical services authorized under subchapter XIX or XXI of the Social Security Act, 42 USC §§1396 to 1396 w-1 5 and 1397aa to 1397mm, must comply with either of the following requirements:

i. A minimum of 1/3 of its Governing Body must be representatives of its membership consisting of Medicaid Enrollees of the organization who are not compensated officers, employees or other individuals responsible for the conduct of, or financially interested in, the organization's affairs or;

ii. The health maintenance organization must establish a Consumer Advisory Committee that reports to the Governing Body. The consumer advisory committee must include at least one Medicaid Enrollee, one family member or legal guardian of an Enrollee and one consumer advocate.

c. If Contractor elects to meet the requirement of MCL 500.3511 by appointing enrollees to its Board of Directors, Contractor must also have an Enrollee Advisory Committee as required by 42 CFR §422.107(f) and set forth in section XXVIII.N below.

d. A health maintenance organization must meet at least quarterly unless specifically exempted from this requirement by the Director. For participation in its non-compensated Governing Body or Consumer Advisory Committee , the Contractor must make good faith efforts to include and actively recruit representation that reflects:

   i. Medicaid Enrollee population in the Contractor's Service Area.

   ii. Parents/guardians of Enrollees in CSHCS.

   iii. Populations identified in Section III.A.

   iv. Medicaid Enrollee populations who have experienced disparate perinatal outcomes.

   v. Groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; gender identity; or geographic location).

e. The Contractor must engage the members of the non-compensated Governing Body or Consumer Advisory Committee in:

   i. developing, prioritizing and evaluating policy and care strategies that promote the reduction of health disparities and advancement of health equity, and

   ii. providing input on culturally appropriate service or program design.

f. Enrollee Board Members. Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan.

23.14 Enrollee Advisory Committee. Pursuant to 42 CFR §422.107(f), Contractor is required to establish an Enrollee Advisory Committee, and must have written policies and procedures for the Enrollee Advisory Committee detailing at a minimum, the following:

A. How council members are chosen.

B. Duties of the Committee members.

C. The length of term for Committee members.

D. Filling of vacancies.

E. How often the Committee reports to the governing body and how minutes or other reports will be shared with MDHHS.

F. How the Committee is involved in developing, prioritizing and evaluating policy and care strategies that promote the reduction of health disparities and advancement of health equity.

G. How the Committee is involved in providing input on culturally appropriate service or program design.

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

A. 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.

B. The relationship of the subcontractor to the Contractor.

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

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

23.16 Geographically Disadvantaged Business Enterprise Sub-Contractors.

A. If contractors plan to utilize subcontractors to perform more than 20% of the deliverables under this contract, at least 20% of that subcontracted work must be awarded to Michigan-based Geographically Disadvantaged Business Enterprises (GDBE). Contractor will submit a plan detailing all subcontractors to be used, including the percentage of the work to be done by each. Contractor must inform the State to the name and address of the GDBE, the percentage of the work they will complete, the total amount estimated to be paid to the GDBE, and provide evidence for their qualifications as a GDBE. If contractor cannot find GDBE subcontractors to meet this requirement they must provide

reasoning and justification to receive an exemption from this requirement from the State. (Existing business relationships will not be an approved reason for this.)

B. GDBE definition: "Geographically Disadvantaged Business Enterprise" also known as GDBE, is a Michigan-based business that satisfies one or more of the following:

   a. Is certified as a Michigan HUBZone Small Business Concern by the United States Small Business Administration.

   b. Has a principal place of business located within a Qualified Opportunity Zone within Michigan.

   c. More than half of its employees either work at a secondary location or have a principal residence located within a Qualified Opportunity Zone within Michigan, or both.

C. Additional information on GDBEs can be found here:

   DTMB - Geographically Disadvantaged Business Enterprise

24 Project Management

24.1 Meetings.

A. Contractor Representatives must attend the following meetings at a cadence that may be updated per MDHHS needs.

   a. Office of Medical Affairs/MHP Medical Directors (quarterly)

   b. CEO (bimonthly)

   c. Operations (monthly)

   d. QI Directors (bimonthly)

   e. Encounter Meeting (monthly)

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.

C. Mandatory Stakeholder Meetings: Contractor must facilitate or otherwise ensure all required meetings with entities named/described in this Contract (e.g., meetings with PIHPs,

Community Collaboration meetings) take place as directed at requisite intervals.

24.2 The State may require the Contractor's personnel to wear State issued identification badges when entering a State facility

24.3 Authorizing Document. The appropriate authorizing document for the Contract will be the Master Agreement.

25 Invoice and Payment.

25.1 Payment Terms.

A. General.

a. Contracts are full-risk.

b. Contractor must fully participate with all State Directed Payments approved by CMS. These State Directed Payments may require Contractors to implement specific payment parameters such as amount, frequency, and provider. The parameters the State establishes with Contractors will be generated based on selection criteria and performance monitoring that has been approved by CMS. State Directed Payments will be incorporated into Contractor rates as necessary/consistent with rate-setting parameters. State Directed Payments may require Contractors to pay hospitals, specialty providers, or PCPs with the goal of ensuring access and high-quality care for Medicaid Enrollees. Contractors must follow payment instructions provided by MDHHS separate from this Contract.

B. Payment Provisions.

a. Fixed Price - Payment under this Contract will consist of a capitated reimbursement plan with specific monthly payments for each enrolled member based on their service level needs as determined by their assigned Program Enrollment Type (PET) code. Capitation payments will be made to the Contractor for each enrolled member in accordance with the actuarially sound rates established for the month in which the capitation payment is made.

b. Capitation Rates.

i. 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 stoploss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government mandated assessments, fees, and taxes imposed by this state and the federal government including the Health Insurer fee that the Contractor incurs and becomes obligated to pay under section 9010 of the Patient Protection and Affordable Care Act, Public Law111-148, as amended by the Health Care and Education Reconciliation Act of 2010, due to its receipt of Medicaid premiums pursuant to the contract. For purposes of this subsection, the full cost of the Health Insurer Fee includes both the Health Insurer Fee and the allowance to reflect the federal and state income tax. The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent capitation rate development methodology that incorporates relevant information which may include:

   (a) The annual financial filings of all Contractors.

   (b) Relevant Medicaid FFS data.

   (c) Relevant Contractor Encounter Data.

ii. 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. Risk Adjustment. Rates have been developed as full risk rates. Contractors assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. No risk corridor, or other risk-mitigation measures, has been established. Any such mechanisms will follow relevant federal guidelines regarding parameters and documentation with rate certification materials.

d. Regional Rate. Rates will include a regional adjustment for the nursing facility population and Community Well populations. Details of the rate adjustment will be detailed in the rate certification and may be adjusted each rate-setting year.

e. Annual Review. MDHHS will annually review changes in implemented Medicaid Policy to determine the financial impact on the HIDE-SNP. Medicaid Policy changes reviewed under this Section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in Covered Services, and modifications to Medicaid rates for Covered Services. If MDHHS determines that the policy changes significantly affect the overall cost to the HIDESNP, MDHHS will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

f. Enrollment Files.

   i. MDHHS will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, MDHHS will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and MDHHS will report payments to Contractors on a HIPAA compliant 820 file. A process will be in place to ensure timely payments and to identify Enrollees the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., those in deeming status). MDHHS may initiate a process to recoup Capitation Payments made to the Contractor for Enrollees who were retroactively disenrolled, Contract Remedies and Performance Bonus Payments.

ii. The application of Contract remedies and performance bonus payments outlined in this Contract will affect the lump-sum payment. Payments in any given calendar year are contingent upon and subject to federal and State appropriations.

(a) 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.

(b) 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.

(c) The State may deduct from whatever is owed to the Contractor of this Contract an amount equal to the Sanctions and/or liquidated damages levied against Contractor.

(d) 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.

i. 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.

26 Medical Loss Ratio (MLR).

26.1 Contractor is subject to a minimum MLR of 85 percent. The MLR provisions apply on a contract-specific basis and include revenue and expense experience applicable to Enrollees included under the Contract.

26.2 Contractor must submit to MDHHS a consolidated MLR report for its Medicaid population for each MLR reporting year, as directed by MDHHS and in accordance with 42 CFR 438.8. Contractor must use the reporting tool provided by MDHHS for MLR reporting requirements for each calendar reporting year of the Contract.

26.3 Failure of Contractor to meet the minimum MLR will result in remittance of funds from Contractor. Within 90 Days of MDHHS' notice to Contractor of its failure to meet the minimum MLR, Contractor must remit back to MDHHS a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 85% multiplied by the revenue paid to Contractor during the Contract year. Rebates paid to MDHHS will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care Program.

27 Contractor Performance Bonus

27.1 Performance Bonus (Quality Withhold).

A. In support of MDHHS' commitment to quality improvement, innovation, and operational excellence, MDHHS will withhold a percentage of the Capitation Payment from Contractor and make

the return of these withheld funds contingent upon Contractor meeting certain quality and performance metrics.

B. Beginning in contract year two (2), MDHHS will withhold 2.00% of the Capitation Payment. MDHHS reserves the right to revise the withhold percentage ahead of each fiscal period. Withheld funds will be used for the Contractor performance bonus awards. Awards will be made to Contractor according to criteria established by MDHHS (see HIDE SNP Quality Withhold Technical Notes) and in compliance with 42 CFR 438.6(b). Contractor's performance will be measured during the rating period in which the withhold arrangement is applied.

27.2 Criteria for Performance Bonus (Quality Withhold).

A. The criteria for awards include but are not limited to assessment of performance in quality of care, access to care, Enrollee satisfaction, and certain administrative functions, as described in Appendix G and the HIDE SNP Quality Withhold Technical Notes. Each year, MDHHS will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

28 Taxes.

28.1 Sales and Use Tax. Generally, the State is exempt from sales and use tax for direct purchases. Contractor's prices must not include sales or use tax unless a specific exception applies.

28.2 Use Tax. Specific Exception: MCL 205.93f sets out a specific exception to the State's general use tax exemption. This exception applies to contracts for purchase of medical services beginning April 1, 2014, from entities identified in MCL 400.106(2)(a) and MCL 400.109f involving certain Medicaid contracted health plans and some specialty prepaid health plans. Purchases of services that fall under these provisions are subject to Use Tax.

28.3 Federal Excise Tax. The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles are purchased under any resulting Contract for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax. d. Employment Taxes. The Contractor must collect and pay all applicable federal, State, and local employment taxes, including the taxes.

28.4 Sales and Use Taxes.

A. Contractor Remittance of Sale Tax. Contractor is required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors lacking sufficient presence in Michigan to be required to register and pay taxes must do so voluntarily. This requirement extends to:

   a. All members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member.

   b. All organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes.

B. Organization Definition. In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in §701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

SCHEDULE B – CAPITATION RATE CERTIFICATION

Contract No. _____

MI Coordinated Health Plan Capitation Rate Certification

The most current Medicaid per member per month capitation rates can be found at:

www.michigan.gov/dsnp

SCHEDULE C - INSURANCE REQUIREMENTS

Contract No. _____

Highly Integrated Dual Eligible Special Needs Plans (HIDE SNP)

1. **General Requirements.** Contractor, at its sole expense, must maintain the insurance coverage as specified herein for the duration of the Term. Minimum limits may be satisfied by any combination of primary liability, umbrella or excess liability, and self-insurance coverage. To the extent damages are covered by any required insurance, Contractor waives all rights against the State for such damages. Failure to maintain required insurance does not limit this waiver.
2. **Qualification of Insurers.** Except for self-insured coverage, all policies must be written by an insurer with an A.M. Best rating of A- VII or higher unless otherwise approved by DTMB Enterprise Risk Management.
3. **Primary and Non-Contributory Coverage.** All policies for which the State of Michigan is required to be named as an additional insured must be on a primary and non-contributory basis.
4. **Claims-Made Coverage.** If any required policies provide claims-made coverage, Contractor must:
   - **a.** Maintain coverage and provide evidence of coverage for at least 3 years after the later of the expiration or termination of the Contract or the completion of all its duties under the Contract;
   - **b.** Purchase extended reporting coverage for a minimum of 3 years after completion of work if coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the Effective Date of this Contract.
5. **Proof of Insurance.**
   - **a.** Insurance certificates showing evidence of coverage as required herein must be submitted to DTMB-RiskManagement@michigan.gov within 10 days of the contract execution date.
   - **b.** Renewal insurance certificates must be provided on annual basis or as otherwise commensurate with the effective dates of coverage for any insurance required herein.
   - **c.** Insurance certificates must be in the form of a standard ACORD Insurance Certificate unless otherwise approved by DTMB Enterprise Risk Management.
   - **d.** All insurance certificates must clearly identify the Contract Number (e.g., notated under the Description of Operations on an ACORD form).

e. The State may require additional proofs of insurance or solvency, including but not limited to policy declarations, policy endorsements, policy schedules, self-insured certification or authorization, and audited financial statements.

f. In the event any required coverage is cancelled or not renewed, Contractor must provide written notice to DTMB Enterprise Risk Management no later than 5 business days following such cancellation or nonrenewal.

6. **Subcontractors.** Contractor is responsible for ensuring its subcontractors, if any, carry and maintain insurance coverage as applicable to the subcontracted service(s).

7. **Limits of Coverage & Specific Endorsements.**

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: **$1,000,000 Each Occurrence** **$1,000,000 Personal & Advertising Injury** **$2,000,000 Products/Completed Operations** **$2,000,000 General Aggregate**	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 20 10 12 19 and CG 20 37 12 19.
Umbrella or Excess Liability Insurance	
Minimum Limits: **$10,000,000 General Aggregate**	Contractor must have their policy follow form.
Automobile Liability Insurance	
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.	

Required Limits	Additional Requirements
Workers' Compensation Insurance	
Minimum Limits: **Coverage according to applicable laws governing work activities.**	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimum Limits: **$500,000 Each Accident** **$500,000 Each Employee by Disease** **$500,000 Aggregate Disease**	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: **$1,000,000 Each Occurrence** **$1,000,000 Annual Aggregate**	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime (Fidelity) Insurance	
Minimum Limits: **$1,000,000 Employee Theft Per Loss**	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: **$3,000,000 Each Occurrence** **$3,000,000 Annual Aggregate**	

8. **Notice of Non-Compliance.** Contractor consents to receiving electronic communications from a third-party service provider, Origami Risk, for the

exclusive purpose of notifying Contractor of non-compliance with the requirements set forth in this Schedule C.

9. **Non-Waiver.** This Schedule C is not intended to and is not to be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations under this Contract, including any provisions hereof requiring Contractor to indemnify, defend and hold harmless the State.

SCHEDULE D - SERVICE LEVEL AGREEMENT FOR HYBRID PURCHASES

1. **Definitions.** For purposes of this Schedule, the following terms have the meanings set forth below. All initial capitalized terms in this Schedule that are not defined in this **Schedule** shall have the respective meanings given to them in the Contract Terms and Conditions.

   "**Actual Uptime**" means the total minutes in the Service Period that the Hosted Services are Available.

   "**Availability**" has the meaning set forth in **Section 2.1**.

   "**Availability Requirement**" has the meaning set forth in **Section 2.1**.

   "**Available**" has the meaning set forth in **Section 2.1**.

   "**Contact List**" means a current list of Contractor contacts and telephone numbers set forth in the attached **Schedule D – Attachment 1** to this Schedule to enable the State to escalate its Support Requests, including: (a) the first person to contact; and (b) the persons in successively more qualified or experienced positions to provide the support sought.

   "**Corrective Action Plan**" has the meaning set forth in **Section 3.9**.

   "**Critical Service Error**" has the meaning set forth in **Section 3.5**.

   "**Exceptions**" has the meaning set forth in **Section 2.2.**

   "**High Service Error**" has the meaning set forth in **Section 3.5.**

   "**Hosted Services**" means the hosting, management and operation of the Operating Environment, Software, other services (including support and subcontracted services), and related resources for remote electronic access and use by the State and its Authorized Users, including any services and facilities related to disaster recovery obligations.

   "**Low Service Error**" has the meaning set forth in **Section 3.5**.

   "**Maintenance Release**" means any update, upgrade, release or other adaptation or modification of the Software, including any updated Documentation, that Contractor may generally provide to its licensees from time to time during the Term, which may contain, among other things, error corrections, enhancements, improvements or other changes to the user interface, functionality, compatibility, capabilities, performance, efficiency or quality of the Software.

   "**Medium Service Error**" has the meaning set forth in **Section 3.5**.

   "**New Version**" means any new version of the Software, including any updated Documentation, that the Contractor may from time to time introduce and market

generally as a distinct licensed product, as may be indicated by Contractor's designation of a new version number.

"**Operating Environment**" means, collectively, the platform, environment and conditions on, in or under which the Software is intended to be installed and operate, as set forth in a Statement of Work, including such structural, functional and other features, conditions and components as hardware, operating software, system architecture, configuration, computing hardware, ancillary equipment, networking, software, firmware, databases, data, and electronic systems (including database management systems).

"**Resolve**" has the meaning set forth in **Section 3.6.**

"**RPO**" **or** "**Recovery Point Objective**" means the maximum amount of potential data loss in the event of a disaster.

"**RTO**" or "**Recovery Time Objective**" means the maximum period of time to fully restore the Hosted Services in the case of a disaster.

"**Scheduled Downtime**" has the meaning set forth in **Section 2.3**.

"**Scheduled Uptime**" means the total minutes in the Service Period.

"**Service Availability Credits**" has the meaning set forth in **Section 2.6(a).**

"**Service Error**" means any failure of any Hosted Service to be Available or otherwise perform in accordance with this Schedule.

"**Service Level Credits**" has the meaning set forth in **Section 3.8**.

"**Service Level Failure**" means a failure to perform the Software Support Services fully in compliance with the Support Service Level Requirements.

"**Service Period**" has the meaning set forth in **Section 2.1**.

"**Software Support Services**" has the meaning set forth in **Section 3**.

"**State Systems**" means the information technology infrastructure, including the computers, software, databases, electronic systems (including database management systems) and networks, of the State or any of its designees.

"**Support Hours**" means 8:00am to 8:00pm

"**Support Request**" has the meaning set forth in **Section 3.5**.

"**Support Service Level Requirements**" has the meaning set forth in **Section 3.4**.

2. **Service Availability and Service Availability Credits.**

2.1. **Availability Requirement.** Contractor will make the Hosted Services and Software Available, as measured over the course of each calendar month during the Term and any additional periods during which Contractor does or is required to perform

any Hosted Services (each such calendar month, a "**Service Period**"), at least 99.98% of the time, excluding only the time the Hosted Services are not Available solely as a result of one or more Exceptions (the "**Availability Requirement**"). "**Available**" means the Hosted Services and Software are available and operable for access and use by the State and its Authorized Users over the Internet in material conformity with the Contract. "**Availability**" has a correlative meaning. The Hosted Services and Software are not considered Available in the event of a material performance degradation or inoperability of the Hosted Services and Software, in whole or in part. The Availability Requirement will be calculated for the Service Period as follows: (Actual Uptime – Total Minutes in Service Period Hosted Services or Software are not Available Due to an Exception) ÷ (Scheduled Uptime – Total Minutes in Service Period Hosted Services or Software are not Available Due to an Exception) x 100 = Availability.

2.2. **Exceptions.** No period of Hosted Services degradation or inoperability will be included in calculating Availability to the extent that such downtime or degradation is due to any of the following ("**Exceptions**"):

(a) Failures of the State's or its Authorized Users' internet connectivity;

(b) Scheduled Downtime as set forth in **Section 2.3**.

2.3 **Scheduled Downtime.** Contractor must notify the State at least twenty-four (24) hours in advance of all scheduled outages of the Hosted Services or Software in whole or in part ("**Scheduled Downtime**"). All such scheduled outages will: (a) last no longer than five (5) hours; (b) be scheduled between the hours of 12:00 a.m. and 5:00 a.m., Eastern Time; and (c) occur no more frequently than once per week; provided that Contractor may request the State to approve extensions of Scheduled Downtime above five (5) hours, and such approval by the State may not be unreasonably withheld or delayed.

2.4 **Software Response Time.** Software response time, defined as the interval from the time the end user sends a transaction to the time a visual confirmation of transaction completion is received, must be less than two (2) seconds for 98% of all transactions. Unacceptable response times shall be considered to make the Software unavailable and will count against the Availability Requirement.

2.5 **Service Availability Reports.** Within thirty (30) days after the end of each Service Period, Contractor will provide to the State a report describing the Availability and other performance of the Hosted Services and Software during that calendar month as compared to the Availability Requirement. The report must be in electronic or such other form as the State may approve in writing and shall include, at a minimum: (a) the actual performance of the Hosted Services and Software relative to the Availability Requirement; and (b) if Hosted Service performance has failed in any respect to meet or exceed the Availability Requirement during the reporting period, a description in sufficient detail to inform the State of the cause of such

failure and the corrective actions the Contractor has taken and will take to ensure that the Availability Requirement are fully met.

2.6 Remedies for Service Availability Failures.

(a) If the actual Availability of the Hosted Services and Software is less than the Availability Requirement for any Service Period, such failure will constitute a Service Error for which Contractor will issue to the State the following credits on the fees payable for Hosted Services and Software provided during the Service Period ("**Service Availability Credits**"):

Availability	**Credit of Fees**
≥99.98%	None
<99.98% but ≥99.0%	15%
<99.0% but ≥95.0%	50%
<95.0%	100%

(b) Any Service Availability Credits due under this **Section** will be applied in accordance with payment terms of the Contract.

(c) If the actual Availability of the Hosted Services and Software is less than the Availability Requirement in any two (2) of four (4) consecutive Service Periods, then, in addition to all other remedies available to the State, the State may terminate the Contract on written notice to Contractor with no liability, obligation or penalty to the State by reason of such termination.

3. Support and Maintenance Services. Contractor will provide IT Environment Service and Software maintenance and support services (collectively, "**Software Support Services**") in accordance with the provisions of this **Section 3**. The Software Support Services are included in the Services, and Contractor may not assess any additional fees, costs or charges for such Software Support Services.

3.1 Support Service Responsibilities. Contractor will:

(b) correct all Service Errors in accordance with the Support Service Level Requirements, including by providing defect repair, programming corrections and remedial programming;

(c) provide unlimited telephone support during **Support Hours**;

(d) provide unlimited online support 24 hours a day, seven days a week;

(e) provide online access to technical support bulletins and other user support information and forums, to the full extent Contractor makes such resources available to its other customers; and

(f) respond to and Resolve Support Requests as specified in this **Section**.

3.2 **Service Monitoring and Management.** Contractor will continuously monitor and manage the Hosted Services and Software to optimize Availability that meets or exceeds the Availability Requirement. Such monitoring and management includes:

(a) proactively monitoring on a twenty-four (24) hour by seven (7) day basis all Hosted Service functions, servers, firewall and other components of Hosted Service security;

(b) if such monitoring identifies, or Contractor otherwise becomes aware of, any circumstance that is reasonably likely to threaten the Availability of the Hosted Service, taking all necessary and reasonable remedial measures to promptly eliminate such threat and ensure full Availability; and

(c) if Contractor receives knowledge that the Hosted Service or any Hosted Service function or component is not Available (including by written notice from the State pursuant to the procedures set forth herein):

(i) confirming (or disconfirming) the outage by a direct check of the associated facility or facilities;

(ii) If Contractor's facility check in accordance with clause (i) above confirms a Hosted Service outage in whole or in part: (A) notifying the State in writing pursuant to the procedures set forth herein that an outage has occurred, providing such details as may be available, including a Contractor trouble ticket number, if appropriate, and time of outage; and (B) working all problems causing and caused by the outage until they are Resolved as Critical Service Errors in accordance with the Support Request Classification set forth in **Section 3.5** and **3.6**, or, if determined to be an internet provider problem, open a trouble ticket with the internet provider; and

(iii) Notifying the State that Contractor has fully corrected the outage and any related problems, along with any pertinent findings or action taken to close the trouble ticket.

3.3 **Service Maintenance.** Contractor will continuously maintain the Hosted Services and Software to optimize Availability that meets or exceeds the Availability Requirement. Such maintenance services include providing to the State and its Authorized Users:

(a) all updates, bug fixes, enhancements, Maintenance Releases, New Versions and other improvements to the Hosted Services and Software, including the Software, that Contractor provides at no additional charge to its other similarly situated customers; provided that Contractor shall consult with the State and is required to receive State approval prior to modifying or upgrading Hosted

Services and Software, including Maintenance Releases and New Versions of Software; and

(b) all such services and repairs as are required to maintain the Hosted Services and Software or are ancillary, necessary or otherwise related to the State's or its Authorized Users' access to or use of the Hosted Services and Software, so that the Hosted Services and Software operate properly in accordance with the Contract and this Schedule.

3.4 **Support Service Level Requirements.** Contractor will correct all Service Errors and respond to and Resolve all Support Requests in accordance with the required times and other terms and conditions set forth in this **Section 3.4** ("**Support Service Level Requirements**"), and the Contract.

3.5 **Support Requests.** The State will classify its requests for Service Error corrections in accordance with the descriptions set forth in the chart below (each a "**Support Request**"). The State will notify Contractor of Support Requests by email, telephone or such other means as the parties may hereafter agree to in writing.

Support Request Classification	**Description:** **Any Service Error Comprising or Causing any of the Following Events or Effects**
Critical Service Error	• Issue affecting entire system or single critical production function; • System down or operating in materially degraded state; • Data integrity at risk; • Declared a Critical Support Request by the State; or • Widespread access interruptions.
High Service Error	• Primary component failure that materially impairs its performance; or • Data entry or access is materially impaired on a limited basis.

Support Request Classification	Description: Any Service Error Comprising or Causing any of the Following Events or Effects
Medium Service Error	• IT Environment Services and Software is operating with minor issues that can be addressed with an acceptable (as determined by the State) temporary work around.
Low Service Error	• Request for assistance, information, or services that are routine in nature.

3.6 **Response and Resolution Time Service Levels.** Response and Resolution times will be measured from the time Contractor receives a Support Request until the respective times Contractor has (i) responded to, in the case of response time and (ii) Resolved such Support Request, in the case of Resolution time. "**Resolve**" (including "**Resolved**", "**Resolution**" and correlative capitalized terms) means that, as to any Service Error, Contractor has provided the State the corresponding Service Error correction and the State has confirmed such correction and its acceptance thereof. Contractor will respond to and Resolve all Service Errors within the following times based on the severity of the Service Error:

Support Request Classification	Service Level Metric (Required Response Time)	Service Level Metric (Required Resolution Time)	Service Level Credits (For Failure to Respond to any Support Request Within the Corresponding Response Time)	Service Level Credits (For Failure to Resolve any Support Request Within the Corresponding Required Resolution Time)
Critical Service Error	One (1) hour	Three (3) hours	Five percent (5%) of the Fees for the month in which the initial Service	Five percent (5%) of the Fees for the month in which the initial

Support Request Classification	Service Level Metric (Required Response Time)	Service Level Metric (Required Resolution Time)	Service Level Credits (For Failure to Respond to any Support Request Within the Corresponding Response Time)	Service Level Credits (For Failure to Resolve any Support Request Within the Corresponding Required Resolution Time)
			Level Failure begins and five percent (5%) of such monthly Fees for each additional hour or portion thereof that the corresponding Service Error is not responded to within the required response time.	Service Level Failure begins and five percent (5%) of such monthly Fees for the first additional hour or portion thereof that the corresponding Service Error remains un-Resolved, which amount will thereafter double for each additional one-hour increment.
High Service Error	One (1) hour	Four (4) hours	Three percent (3%) of the Fees for the month in which the initial Service Level Failure begins and three percent (3%) of such monthly Fees for each additional	Three percent (3%) of the Fees for the month in which the initial Service Level Failure begins and three percent (3%) of such monthly Fees for the first

Support Request Classification	Service Level Metric (Required Response Time)	Service Level Metric (Required Resolution Time)	Service Level Credits (For Failure to Respond to any Support Request Within the Corresponding Response Time)	Service Level Credits (For Failure to Resolve any Support Request Within the Corresponding Required Resolution Time)
			hour or portion thereof that the corresponding Service Error is not responded to within the required response time.	additional hour or portion thereof that the corresponding Service Error remains un-Resolved, which amount will thereafter double for each additional one-hour increment.
Medium Service Error	Three (3) hours	Two (2) Business Days	N/A	N/A
Low Service Error	Three (3) hours	Five (5) Business Days	N/A	N/A

3.7 **Escalation**. With respect to any Critical Service Error Support Request, until such Support Request is Resolved, Contractor will escalate that Support Request within sixty (60) minutes of the receipt of such Support Request by the appropriate Contractor support personnel, including, as applicable, the Contractor Project Manager and Contractor's management or engineering personnel, as appropriate.

3.8 **Support Service Level Credits**. Failure to achieve any of the Support Service Level Requirements for Critical and High Service Errors will constitute a Service Level Failure for which Contractor will issue to the State the corresponding service

credits set forth in **Section 3.6** ("**Service Level Credits**") in accordance with payment terms set forth in the Contract.

3.9 **Corrective Action Plan.** If two or more Critical Service Errors occur in any thirty (30) day period during (a) the Term or (b) any additional periods during which Contractor does or is required to perform any Hosted Services, Contractor will promptly investigate the root causes of these Service Errors and provide to the State within five (5) Business Days of its receipt of notice of the second such Support Request an analysis of such root causes and a proposed written corrective action plan for the State's review, comment and approval, which, subject to and upon the State's written approval, shall be a part of, and by this reference is incorporated in, the Contract as the parties' corrective action plan (the "**Corrective Action Plan**"). The Corrective Action Plan must include, at a minimum: (a) Contractor's commitment to the State to devote the appropriate time, skilled personnel, systems support and equipment and other resources necessary to Resolve and prevent any further occurrences of the Service Errors giving rise to such Support Requests; (b) a strategy for developing any programming, software updates, fixes, patches, etc. necessary to remedy, and prevent any further occurrences of, such Service Errors; and (c) time frames for implementing the Corrective Action Plan. There will be no additional charge for Contractor's preparation or implementation of the Corrective Action Plan in the time frames and manner set forth therein.

4. **Data Storage, Backup, Restoration and Disaster Recovery**. Contractor must maintain or cause to be maintained backup redundancy and disaster avoidance and recovery procedures designed to safeguard State Data and the State's other Confidential Information, Contractor's Processing capability and the availability of the IT Environment Services and Software, in each case throughout the Term and at all times in connection with its actual or required performance of the Services hereunder. All backed up State Data shall be located in the continental United States. The force majeure provisions of this Contract do not limit Contractor's obligations under this section**.**

4.2 **Data Storage.** Contractor will provide sufficient storage capacity to meet the needs of the State at no additional cost.

4.3 **Data Backup.** Contractor will conduct, or cause to be conducted, daily back-ups of State Data and perform, or cause to be performed, other periodic offline back-ups of State Data on at least a weekly basis and store and retain such back-ups as specified in **Schedule A**. Contractor must, within five (5) Business Days of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to Contractor), an extract of State Data in the format specified by the State**.**

4.4 **Data Restoration.** If the data restoration is required due to the actions or inactions of the Contractor or its subcontractors, Contractor will promptly notify the State and complete actions required to restore service to normal production operation.

If requested, Contractor will restore data from a backup upon written notice from the State. Contractor will restore the data within one (1) Business Day of the State's request. Contractor will provide data restorations at its sole cost and expense.

4.5 **Disaster Recovery.** Throughout the Term and at all times in connection with its actual or required performance of the Services, Contractor will maintain and operate a backup and disaster recovery plan to achieve a Recovery Point Objective (RPO) of 24 hours, and a Recovery Time Objective (RTO) of 48 hours (the "**DR Plan**"), and implement such DR Plan in the event of any unplanned interruption of the Hosted Services. Contractor's current DR Plan, revision history, and any reports or summaries relating to past testing of or pursuant to the DR Plan are included or attached as described in **Schedule A** under **Hosting**. Contractor will actively test, review and update the DR Plan on at least an annual basis using industry best practices as guidance. Contractor will provide the State with copies of all such updates to the Plan within fifteen (15) days of its adoption by Contractor. All updates to the DR Plan are subject to the requirements of this **Section 3**; and provide the State with copies of all reports resulting from any testing of or pursuant to the DR Plan promptly after Contractor's receipt or preparation. If Contractor fails to reinstate all material Hosted Services and Software within the periods of time set forth in the DR Plan, the State may, in addition to any other remedies available under this Contract, in its sole discretion, immediately terminate this Contract as a non-curable default.

SCHEDULE E - DATA SECURITY REQUIREMENTS FOR HYBRID PURCHASES

1. **Definitions.** For purposes of this Schedule, the following terms have the meanings set forth below. All initial capitalized terms in this Schedule that are not defined in this **Schedule** shall have the respective meanings given to them in the Contract.

"**Contractor Security Officer**" has the meaning set forth in **Section 2** of this Schedule.

"**FedRAMP**" means the Federal Risk and Authorization Management Program, which is a federally approved risk management program that provides a standardized approach for assessing and monitoring the security of cloud products and services.

"**FISMA**" means The Federal Information Security Modernization Act of 2014 (Pub.L. No. 113-283 (Dec. 18, 2014.).

"Hosting Provider" means any subcontractor that is providing any or all of the Hosted Services under this Contract.

"Hosted Services" means the hosting, management and operation of the Operating Environment, Software, other services (including support and subcontracted services), and related resources for remote electronic access and use by the State and its Authorized Users, including any services and facilities related to disaster recovery obligations.

"**NIST**" means the National Institute of Standards and Technology.

"**Operating Environment**" means, collectively, the platform, environment and conditions on, in or under which the Software is intended to be installed and operate, as set forth in a Statement of Work, including such structural, functional and other features, conditions and components as hardware, operating software, system architecture, configuration, computing hardware, ancillary equipment, networking, software, firmware, databases, data, and electronic systems (including database management systems).

"**PCI**" means the Payment Card Industry.

"Process" means to perform any operation or set of operations on any data, information, material, work, expression or other content, including to (a) collect, receive, input, upload, download, record, reproduce, store, organize, combine, log, catalog, cross-reference, manage, maintain, copy, adapt, alter, translate or make other improvements or derivative works, (b) process, retrieve, output, consult, use, disseminate, transmit, submit, post, transfer, disclose or otherwise provide or make available, or (c) block, erase or destroy. **"Processing"** and **"Processed"** have correlative meanings.

"**PSP**" or **"PSPs"** means the State's IT Policies, Standards and Procedures.

"**SSAE**" means Statement on Standards for Attestation Engagements.

"**Security Accreditation Process**" has the meaning set forth in **Section 6** of this Schedule

2. **Security Officer.** Contractor will appoint a Contractor employee to respond to the State's inquiries regarding the security of the Hosted Services who has sufficient knowledge of the security of the Hosted Services and the authority to act on behalf of Contractor in matters pertaining thereto ("**Contractor Security Officer**").

3. **Contractor Responsibilities.** Contractor is responsible for establishing and maintaining a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to:

   (a) ensure the security and confidentiality of the State Data;

   (b) protect against any anticipated threats or hazards to the security or integrity of the State Data;

   (c) protect against unauthorized disclosure, access to, or use of the State Data;

   (d) ensure the proper disposal of any State Data in Contractor's or its subcontractor's possession; and

   (e) ensure that all Contractor Representatives comply with the foregoing.

   The State has established Information Technology (IT) PSPs to protect IT resources under the authority outlined in the overarching State 1305.00 Enterprise IT Policy. In no case will the safeguards of Contractor's data privacy and information security program be less stringent than the safeguards used by the State, and Contractor must at all times comply with all applicable public and non-public State IT policies and standards, of which the publicly available ones are at DTMB - IT Policies, Standards & Procedures (michigan.gov).

   This responsibility also extends to all service providers and subcontractors with access to State Data or an ability to impact the contracted solution. Contractor responsibilities are determined from the PSPs based on the services being provided to the State, the type of IT solution, and the applicable laws and regulations.

4. **Acceptable Use Policy.** To the extent that Contractor has access to the State's IT environment, Contractor must comply with the State's Acceptable Use Policy, see 1340.00.130.02 Acceptable Use of Information Technology (michigan.gov). All

Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing State systems. The State reserves the right to terminate Contractor's and/or subcontractor(s) or any Contractor Personnel's access to State systems if the State determines a violation has occurred.

5. **Protection of State's Information.** Throughout the Term and at all times in connection with its actual or required performance of the Contract Activities, Contractor will:

5.1 If Hosted Services are provided by a Hosting Provider, ensure each Hosting Provider maintains FedRAMP authorization for all Hosted Services environments throughout the Term, and in the event a Hosting Provider is unable to maintain FedRAMP authorization, the State, at its sole discretion, may either a) require the Contractor to move the Software and State Data to an alternative Hosting Provider selected and approved by the State at Contractor's sole cost and expense without any increase in Fees, or b) immediately terminate this Contract for cause pursuant to **Section 25** of the Contract;

5.2 for Hosted Services provided by the Contractor, maintain either a FedRAMP authorization or an annual SSAE 18 SOC 2 Type II audit based on State required NIST Special Publication 800-53 MOD Controls using identified controls and minimum values as established in applicable State PSPs.

5.3 ensure that the Software and State Data is securely stored, hosted, supported, administered, accessed, developed, and backed up in the continental United States, and the data center(s) in which the data resides minimally meet Uptime Institute Tier 3 standards (www.uptimeinstitute.com), or its equivalent;

5.4 maintain and enforce an information security program including safety and physical and technical security policies and procedures with respect to its Processing of the State Data that complies with the requirements of the State's data security policies as set forth in this Contract, and must, at a minimum, remain compliant with FISMA and NIST Special Publication 800-53 MOD Controls using identified controls and minimum values as established in applicable State PSPs;

5.5 provide technical and organizational safeguards against accidental, unlawful or unauthorized access to or use, destruction, loss, alteration, disclosure, encryption, transfer, commingling or processing of such information that ensure a level of security appropriate to the risks presented by the processing of State Data and the nature of such State Data, consistent with best industry practice and applicable standards (including, but not limited to, compliance with FISMA, NIST, CMS, IRS, FBI, SSA, HIPAA, FERPA and PCI requirements as applicable);

5.6 take all reasonable measures to:

(a) secure and defend all locations, equipment, systems and other materials and facilities employed in connection with the Contract Activities against "malicious actors" and others who may seek, without authorization, to destroy, disrupt, damage, encrypt, modify, copy, access or otherwise use Hosted Services or the information found therein; and

(b) prevent (i) the State and its Authorized Users from having access to the data of other customers or such other customer's users of the Contract Activities; (ii) State Data from being commingled with or contaminated by the data of other customers or their users of the Contract Activities; and (iii) unauthorized access to any of the State Data;

5.7 ensure that State Data is encrypted in transit and at rest using FIPS validated AES encryption modules and a key size of 128 bits or higher;

5.8 ensure the Hosted Services support Identity Federation/Single Sign-on (SSO) capabilities using Security Assertion Markup Language (SAML), Open Authentication (OAuth) or comparable State approved mechanisms;

5.9 ensure the Hosted Services implements NIST compliant multi-factor authentication for privileged/administrative and other identified access.

6. **Security Accreditation Process.** Throughout the Term, Contractor will assist the State, at no additional cost, with its **Security Accreditation Process**, which includes the development, completion and on-going maintenance of a system security plan (SSP) using the State's automated governance, risk and compliance (GRC) platform, which requires Contractor to submit evidence, upon request from the State, in order to validate Contractor's security controls within two weeks of the State's request. On an annual basis, or as otherwise required by the State such as for significant changes, re-assessment of the system's controls will be required to receive and maintain authority to operate (ATO). All identified risks from the SSP will be remediated through a Plan of Action and Milestones (POAM) process with remediation time frames and required evidence based on the risk level of the identified risk. For all findings associated with the Contractor's solution, at no additional cost, Contractor will be required to create or assist with the creation of State approved POAMs, perform related remediation activities, and provide evidence of compliance. The State will make any decisions on acceptable risk, Contractor may request risk acceptance, supported by compensating controls, however only the State may formally accept risk. Failure to comply with this section will be deemed a material breach of the Contract.

7. **Unauthorized Access.** Contractor may not access, and must not permit any access to, State systems, in whole or in part, whether through the Hosted Services or otherwise, without the State's express prior written authorization. Such authorization may be revoked by the State in writing at any time in its sole discretion. Any access to State systems must be solely in accordance with the Contract and this Schedule, and in no case exceed the scope of the State's authorization pursuant to this Section. All State-authorized connectivity or attempted connectivity to State systems shall be only through the State's security gateways and firewalls and in compliance with the State's security policies set forth in the Contract as the same may be supplemented or amended by the State and provided to Contractor from time to time.

8. **Security Audits.**

8.1 During the Term, Contractor will maintain complete and accurate records of its data protection practices, IT security controls, and the security logs relating to State Data, including but not limited to any backup, disaster recovery or other policies, practices or procedures relating to the State Data and any other information relevant to its compliance with this Contract.

8.2 Without limiting any other audit rights of the State, the State has the right to review Contractor's data privacy and information security program prior to the commencement of Contract Activities and from time to time during the term of this Contract. The State, at its own expense, is entitled to perform, or to have performed, an on-site audit of Contractor's data privacy and information security program. If the State chooses to perform an on-site audit, Contractor will, make all such records, appropriate personnel and relevant materials available during normal business hours for inspection and audit by the State or an independent data security expert that is reasonably acceptable to Contractor, provided that the State: (i) gives Contractor at least five (5) Business Days prior notice of any such audit; (ii) undertakes such audit no more than once per calendar year, except for good cause shown; and (iii) conducts or causes to be conducted such audit in a manner designed to minimize disruption of Contractor's normal business operations and that complies with the terms and conditions of all data confidentiality, ownership, privacy, security and restricted use provisions of the Contract. The State may, but is not obligated to, perform such security audits, which shall, at the State's option and request, include penetration and security tests, of any and all Hosted Services and their housing facilities and operating environments.

8.3 During the Term, Contractor will, when requested by the State, provide a copy of Contractor's and Hosting Provider's FedRAMP System Security Plan(s) or SOC 2

Type 2 report(s) to the State within two weeks of the State's request. The System Security Plan and SSAE audit reports will be recognized as Contractor's Confidential Information.

8.4 With respect to State Data, Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

8.5 The State reserves the right, at its sole election, to immediately terminate this Contract or a Statement of Work without limitation and without liability if the State determines that Contractor fails or has failed to meet its obligations under this **Section 8.**

9. Application Scanning. During the Term, Contractor must, at its sole cost and expense, scan all Contractor provided applications, and must analyze, remediate and validate all vulnerabilities identified by the scans as required by the State Secure Web Application and other applicable PSPs.

Contractor's application scanning and remediation must include each of the following types of scans and activities:

9.1 Dynamic Application Security Testing (DAST) – Scanning interactive application for vulnerabilities, analysis, remediation, and validation (may include Interactive Application Security Testing (IAST).

(a) Contractor must either a) grant the State the right to dynamically scan a deployed version of the Software; or b) in lieu of the State performing the scan, Contractor must dynamically scan a deployed version of the Software using a State approved application scanning tool, and provide the State with a vulnerabilities assessment after Contractor has completed such scan. These scans and assessments i) must be completed and provided to the State quarterly (dates to be provided by the State) and for each major release; and ii) scans must be completed in a non-production environment with verifiable matching source code and supporting infrastructure configurations or the actual production environment.

9.2 Static Application Security Testing (SAST) - Scanning source code for vulnerabilities, analysis, remediation, and validation.

(a) For Contractor provided applications, Contractor, at its sole expense, must provide resources to complete static application source code scanning, including the analysis, remediation and validation of vulnerabilities identified by

application source code scans. These scans must be completed for all source code initially, for all updated source code, and for all source code for each major release and Contractor must provide the State with a vulnerability assessment after Contractor has completed the required scans.

9.3 Software Composition Analysis (SCA) – Third Party and/or Open Source Scanning for vulnerabilities, analysis, remediation, and validation.

(a) For Software that includes third party and open source software, all included third party and open source software must be documented and the source supplier must be monitored by the Contractor for notification of identified vulnerabilities and remediation. SCA scans may be included as part of SAST and DAST scanning or employ the use of an SCA tool to meet the scanning requirements. These scans must be completed for all third party and open source software initially, for all updated third party and open source software, and for all third party and open source software in each major release and Contractor must provide the State with a vulnerability assessment after Contractor has completed the required scans if not provided as part of SAST and/or DAST reporting.

9.4 In addition, application scanning and remediation may include the following types of scans and activities if required by regulatory or industry requirements, data classification or otherwise identified by the State.

(a) If provided as part of the solution, all native mobile application software must meet these scanning requirements including any interaction with an application programing interface (API).

(b) Penetration Testing – Simulated attack on the application and infrastructure to identify security weaknesses.

10. Infrastructure Scanning.

10.1 For Hosted Services, Contractor must ensure the infrastructure and applications are scanned using an approved scanning tool (Qualys, Tenable, or other PCI Approved Vulnerability Scanning Tool) at least monthly and provide the scan's assessments to the State in a format that is specified by the State and used to track the remediation. Contractor will ensure the remediation of issues identified in the scan according to the remediation time requirements documented in the State's PSPs.

11. Nonexclusive Remedy for Security Breach. Any failure of the Contract Activities to meet the requirements of this Schedule with respect to the security of any State Data or other Confidential Information of the State, including any related backup, disaster recovery or other policies, practices or procedures, is a material breach of the Contract for which the State, at its option, may terminate the Contract immediately upon written notice to Contractor without any notice or cure period, and Contractor must promptly reimburse to the State any Fees prepaid by the State prorated to the date of such termination.

SCHEDULE F - HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the Michigan Department of Technology, Management and Budget ("DTMB", "Business Associate 1") on behalf of the Michigan Department of Health and Human Services ("Covered Entity") and **<Plan Name>.** "Business Associate 2".

RECITALS

A. Under this Agreement, Business Associate 2 will collect or receive certain information on the Covered Entity's behalf, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, the Business Associate agrees to protect the privacy and security of the information as set forth in this Agreement.

B. Covered Entity and each Business Associate intend to protect the privacy and provide for the security of PHI collected or received by the Business Associate under the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HIPAA Rules, as amended.

C. The HIPAA Rules require the Covered Entity to enter into an agreement containing specific requirements with Business Associate 1, and likewise Business Associate 1 must enter an agreement with Business Associate 2 before the Business Associate 2's receipt of PHI.

AGREEMENT

1. Definitions.

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

   b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103 and regarding this Agreement means DTMB ("Business Associate 1") and <Plan Name>. ("Business Associate 2").

c. “Covered Entity” has the same meaning as the term “covered entity” at 45 CFR 160.103 and regarding this Agreement means the Michigan Department of Health and Human Services.

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

2. Obligations of Business Associate 2.

Business Associate 2 agrees to:

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

b. implement and use appropriate safeguards and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Agreement. Business Associate 2 must maintain, and provide a copy to the Covered Entity and Business Associate 1 within 10 days of a request from the Covered Entity or Business Associate 1, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of Business Associate 2’s operations and the nature and the scope of its activities.

c. report to the Covered Entity and Business Associate 1 within 24 hours of any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If Business Associate 2 is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and Business Associate 2 will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services’ Office for Civil Rights, and potentially the media.

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

subcontractors that violate such restrictions and conditions and must mitigate the effects of any such violation.

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

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under, 45 CFR § 164.526. If any individual requests an amendment of PHI directly from Business Associate 2 or its agents or subcontractors, Business Associate 2 must notify the Covered Entity in writing within five days of the request and amend the information within ten days of the request. Any denial of amendment of PHI maintained by Business Associate 2 or its agents or subcontractors is the responsibility of Business Associate 2.

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

h. to the extent Business Associate 2 is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity when performing those obligations.

i. make its internal practices, books, and records relating to Business Associate 2's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate 2 must concurrently provide to the Covered Entity a copy of any PHI that the Business Associate 2 provides to the Secretary.

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

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

l. within ten days of a written request by the Covered Entity, Business Associate 2 and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Agreement. Business Associate 2 and the Covered Entity will mutually agree in advance upon the scope, timing and location of such an inspection. Covered Entity must protect the confidentiality of all confidential and proprietary information of Business Associate 2 to which the Covered Entity has access during the course of such inspection. Covered Entity and Business Associate 2 will execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate 2's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate 2 of its responsibility to comply with this Agreement. Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Agreement.

3. <u>Permitted Uses and Disclosures by the Business Associate</u>.

a. Business Associate 2 may use or disclose PHI:
(1) for the proper management and administration of Business Associate 2 or to carry out the legal responsibilities of Business Associate 2; provided, however, either (A) the disclosures are required by law, or (B) Business Associate 2 obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate 2 of any instances of which it is aware in which the confidentiality of the information has been breached;

(2) as required by law;
(3) for Data Aggregation services relating to the health care operations of the Covered Entity;
(4) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If Business Associates 2 de-identifies the PHI it receives from the Covered Entity, Business Associate 2 may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and
(5) for any other purpose listed here: Purposes outside the scope of the Contract are not permissible.

b. Business Associate 2 agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate 2 may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations

Covered entity agrees to:

a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to Business Associate 2 under this Agreement until the PHI is received by Business Associate 2.
b. provide Business Associate 2 with a copy of its Notice of Privacy Practices and must notify the Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect Business Associate 2's use or disclosure of PHI.
c. notify Business Associate 2 of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect Business Associate 2's use or disclosure of PHI.
d. notify Business Associate 2 of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect Business Associate 2's use or disclosure of PHI.

5. Term. This Agreement continues in effect until terminated or is replaced with a new agreement between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Agreement regarding breach, a breach by Business Associate 2 of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreement and provides grounds for Business Associate 1 to terminate this Agreement for cause at the request of Covered Entity. Termination for cause is subject to 6.b.:

   (1) Default. If Business Associate 2 refuses or fails to timely perform any of the provisions of this Agreement, the Covered Entity may notify Business Associate 2 in writing of the non-performance, and if not corrected within thirty days, Business Associate 1 may immediately terminate the Agreement at the request of Covered Entity. The Business Associate 2 must continue performance of the Agreement to the extent it is not terminated.

   (2) Business Associate 2's Duties. Notwithstanding termination of the Agreement, and subject to any directions from the Covered Entity or Business Associate 1, Business Associate 2 must protect and preserve property in the possession of Business Associate 2 in which the Covered Entity has an interest.

   (3) Erroneous Termination for Default. If Business Associate 1 terminates this Agreement at the request of Covered Entity under Section 6(a) and after such termination it is determined, for any reason, that Business Associate 2 was not in default, then such termination will be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Agreement had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity or Business Associate 1 knows of a pattern of activity or practice of Business Associate 2 that constitutes a material breach or violation of Business Associate 2's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement under Section 6(a), then the Business Associate 1, at the request of Covered Entity or on its own accord, must notify Business Associate 2 of the pattern of activity or practice. Business Associate 2 must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate 2's efforts to cure such breach or end such violation are unsuccessful, Business Associate 1, at the request of the Covered Entity or on its own accord, may either (i) terminate this Agreement, if feasible or (ii) report Business Associate 2's breach or violation to the Secretary.

c. Effect of Termination. After termination of this Agreement for any reason, the Business Associate, with respect to PHI it received from the Covered Entity, or created, maintained, or received by Business Associate 2 on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for Business Associate 2 to continue its proper management and administration or to carry out its legal responsibilities;
(2) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that Business Associate 2 still maintains in any form;
(3) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate 2 retains the PHI;
(4) not use or disclose the PHI retained by Business Associate 2 other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and
(5) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by Business Associate 2 when it is no longer needed by Business Associate 2 for its proper management and administration or to carry out its legal responsibilities.

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

8. Data Ownership. Business Associate 2 has no ownership rights in the PHI. The covered entity retains all ownership rights of the PHI.

9. Disclaimer. Neither Business Associate 1, nor the Covered Entity, warrants or represents that compliance by Business Associate 2 with this Agreement, HIPAA, or the HIPAA Rules will be adequate or satisfactory for Business Associate 2's own purposes. Business Associate 2 is solely responsible for all decisions made by Business Associate 2 regarding the safeguarding of PHI.

10. Certification. If the Covered Entity determines an examination is necessary to comply with the Covered Entity's legal obligations under HIPAA relating to certification of its security practices, the Covered Entity or its authorized agents or contractors, may, at the Covered Entity's expense, examine Business Associate 2's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Covered Entity the extent to which Business Associate 2's security safeguards comply with HIPAA, the HIPAA Rules or this Agreement.

11. Amendment. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an

amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA and the HIPAA Rules. Either party may terminate the Agreement upon thirty days written notice if (i) one party does not promptly enter into negotiations to amend this Agreement when requested by the other party or (ii) Business Associate 2 does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA or the HIPAA Rules.

12. Assistance in Litigation or Administrative Proceedings. Business Associate 2 must make itself, and any subcontractors, employees or agents assisting Business Associate 2 in the performance of its obligations under this Agreement, available to the Covered Entity or Business Associate 1, at no cost to the Covered Entity or Business Associate 1, to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against the Covered Entity or Business Associate 1, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules or other laws relating to Business Associate 2's or its subcontractors use or disclosure of PHI under this Agreement, except where Business Associate 2 or its subcontractor, employee or agent is a named adverse party.

13. No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer upon any person other than the Covered Entity, Business Associate 1, Business Associate 2 and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Interpretation and Order of Precedence. Any ambiguity in this Agreement must be interpreted to permit compliance with the HIPAA Rules. Where the provisions of this Agreement differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement control.

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

16. Survival of Certain Agreement Terms. Notwithstanding any contrary provision in this Agreement, the Business Associate 2's obligations under Section 6(d) and record retention laws ("Effect of Termination") and Section 12 ("No Third-Party Beneficiaries") survive termination of this Agreement and are enforceable by the Covered Entity or Business Associate 1.

17. Representatives and Notice.

a. Representatives. The individuals listed below are designated as the parties' respective representatives for purposes of this Agreement. Either party may from time to time designate in writing new or substitute representatives.

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

Covered Entity Representative:

Privacy and Security Manager
MDHHS Compliance Office
333 South Grand Ave, 4th Floor
Lansing, MI 48933

Business Associate 1 Representative:

Name:
Title: Category Specialist
Department: Michigan Department of Technology, Management & Budget
Address: 320 South Walnut Street, Lansing, MI 48933
Phone:
Email:

Business Associate 2 Representative:

Name:
Title:
Department:
Address:
Phone:
Email:

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

DTMB as Business Associate 1, on behalf of the Michigan Department of Health and Human Services	**Business Associate 2** <Plan Name>
By: _____	By: _____

Date: _____	Date: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____

Appendix A – Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the demonstration, 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 program.

Action - As defined in 42 CFR §431.201, a termination, suspension of, or reduction in covered benefits or services, or a termination, suspension of, or reduction in Medicaid eligibility or an increase in Enrollee liability, including a determination that Enrollee must incur a greater amount of medical expenses in order to establish income eligibility in accordance with 42 CFR §435.121(e)(4) or §435.831 or is subject to an increase in premiums or cost-sharing charges under 42 CFR Part 447, subpart A. It also means a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State with regard to the preadmission screening and resident review requirements of section 1919(e)(7) of the Act.

Additional Assessments - Additional assessments are identified based upon findings from the Health Risk Assessment Tool and are appropriate when an enrollee shows a potential need for follow up assessment(s) for BH, I/DD, SUD, LTSS services, or any other healthcare need. The plan may conduct additional assessments itself or contract with an appropriate external vendor.

Advance Directive - An individual's written directive or instruction, such as a power of attorney for health care or a living will, for the provision of that individual's health care if the individual is unable to make their health care wishes known.

Adverse Benefit Determination - As defined in 42 CFR §438.400(b), any of the following (i) 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; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b) is not an Adverse Benefit Determination; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of Contractor to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, 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; (vii) the denial of an Enrollee's request to dispute a financial liability, including without

limitation, cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Adverse Events - An event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient, also referred to as a Serious Reportable Event. Aligned with the Serious Reportable Event categories defined by the National Quality Forum.

Alternative Format - Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are blind or vision impaired or have limited English reading proficiency. Examples of Alternative Formats must include, but not be limited to, braille, large font, audio, video, non-English language translation, and information read aloud to the Enrollee.

Alternative Payment Methodologies - Payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service (FFS) basis.

Alternative Payment Models (APM) - A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. At times, the term APM is used interchangeably with Value-Based Payment (VBP).

Appeal - As defined in 42 CFR 438.400(b), a request for review by Contractor of an adverse Organization Determination, and as defined in 42 CFR §422.561, any of the procedures that deal with the review of adverse Organization Determinations on the health care services the Enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Enrollee), or on any amounts Enrollee must pay for a service, as defined under 42 CFR §422.566(b) and this Contract. These procedures include Reconsiderations by Contractor, and if necessary, an independent review entity, hearings, ALJs, review by the Medicare Appeals Council (Council), and judicial review. The term Appeal(s) when used in this Contract includes Integrated Appeals.

Appeal Decision Letter - As required by 42 CFR §422.633(f)(4), Contractors must send written notices when denying an Enrollee's plan-level Integrated Appeal that are substantially similar to model materials referenced in the CMS Medicare-Medicaid Coordination Office letter "Contract Year (CY) 2021 D-SNP Integrated Notices Memorandum (dated November 20, 2020)." Required letters include the "Letter about Your Right to Make a Fast Complaint," and "Appeal Decision Letter." The Appeal Decision Letter, along with the other letters and guidance are available at: https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements.

Applicable Integrated Plan – A fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan with exclusively aligned enrollment; and the Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization; or

A dual eligible special needs plan and affiliated Medicaid managed care plan where—

The dual special needs plan, by MDHHS policy, has enrollment limited to those beneficiaries enrolled in a Medicaid managed care organization as described in paragraph (B) of this definition;

There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization; and a Medicaid agency; or a Medicaid managed care organization as defined in section 1903(m) of the Act that contracts with the Medicaid agency; and

Through the capitated contract described in (B) of this definition, Medicaid benefits including primary care and acute care, including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries, and at a minimum, one of the following: Home health services as defined in §440.70 of this chapter, medical supplies, equipment, and appliances as described in §440.70(b)(3) of this chapter, or nursing facility services are covered for the enrollees.

Audit 834 List - Official list of HIDE SNP enrollment.

Authorized Representative or Representative - As defined in §42 CFR §422.561, an individual appointed by an Enrollee or other party, or authorized under State or other applicable law, to act on behalf of an Enrollee or other party involved in the Grievance or Appeal. Unless otherwise stated in Subpart M of 42 CFR §422, the Representative must have all rights and responsibilities of an Enrollee or party filing a Grievance, and in obtaining an Integrated Organization Determination or in dealing with any of the levels of Appeals process, subject to the applicable rules described in 42 CFR Part 405.

Behavioral Health Inpatient Services - Services provided in a hospital setting to include inpatient medical/surgical/psychiatric.

Behavioral Health Outpatient Services - Services that are provided in the home or community setting and to Enrollees who can return home after care without an overnight stay in a hospital or other inpatient facility.

Behavioral Health Services - Services that assist people with needs related to a mental illness, intellectual/developmental disability, and/or substance use disorder.

Business Continuity and Disaster Recovery (BC-DR) - A plan that specifies what actions the ICO must conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency, including but not limited to localized acts of nature, accidents, and technological and/or attack-related emergencies.

Capitation Payment - A payment MDHHS makes periodically to a Contractor on behalf of each Enrollee under this Contract for the provision of services within this Contract, regardless of whether the Enrollees receive services during the period covered by the payment. Any and all costs incurred by Contractor in excess of a Capitation Payment must be borne in full by Contractor.

CareConnect360 - A web portal to support care coordination of Enrollees' physical health and behavioral health conditions. The portal provides Contractors and Prepaid Inpatient Health Plans (PIHPs) access to Medicaid and limited Medicare Claims information in the MDHHS Data Warehouse related to both physical and behavioral health care. Due to federal confidentiality requirements, Substance Use Disorder information is not included in the Claim data.

Care Coordination - A process used by a person or team to assist Enrollees in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.

Care Coordination Platform - An electronic platform supported by web-based technology that will manage communication and information flow regarding referrals, care transitions, and care delivery; facilitate timely and thorough coordination and communication among the Enrollee, Contractor, the primary care provider, and other providers; provide prior authorization information for services; and house the Electronic Health Record.

Care Coordinator - A Michigan licensed registered nurse, nurse practitioner, physician's assistant, limited licensed or fully licensed Bachelor's or Master's prepared social worker, or clinical nurse specialist employed or contracted with Contractor who is accountable for providing the full range of Care Coordination services described in this contract and who is trained in person-centered planning techniques. Qualifications of the HIDE SNP Care Coordinator and responsibilities are outlined in Section 6.8 respectively.

Center for Medicare and Medicaid Innovation (CMMI) - Established by Section 3021 of the Affordable Care Act, CMMI was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

Centers for Medicare & Medicaid Services (CMS) - The federal agency under Department of Health and Human Services responsible for administering the Medicare and Medicaid programs, among other programs.

Claim - An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS-1500 or UB-04, or their successor forms. LTSS providers may submit Claims via paper or electronic invoice or a cash register receipt or a service/work.

Clean Claim - All claims as defined in 42 CFR § 447.45 and MCL 400.111i.

CMS - See Centers for Medicare & Medicaid Services (CMS).

Community Based Health - A strong focus on the Social Determinants of Health, coordinating Population Health improvement strategies.

Community Based Organizations - Non-profit, non-governmental, or charitable organizations that represent community needs and work to improve them.

Community Health Automated Medicaid Processing System (CHAMPS) - See Medicaid Management Information System.

Community Mental Health Services Program (CMHSP) - A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended. CMHSPs provide publicly funded (Medicaid, Medicare, General Fund, in addition to other local fund sources) behavioral health services directly and/or through contractual arrangements. CMHSPs may also provide behavioral health services to beneficiaries residing in Medicare and/or Medicaid certified nursing facilities through the Omnibus Budget Reconciliation Act (OBRA) Pre-Admission Screening and Resident Review (PASARR) program requirements.

Community Supports – Supports or services that are non-reimbursed or are provided through entities such as churches, senior centers, or community resources.

Community Transition Services (CTS) - Community Transition Services are Home and Community-Based Services for Medicaid beneficiaries who meet eligibility criteria. The benefit is administered by the Michigan Department of Health and Human Services on a fee-for-service basis through transition agencies including Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations. Enrollees eligible for CTS include nursing facility and institutional residents who meet needs-based criteria and have at least one risk factor as described in the CTS chapter of the Michigan Medicaid Provider Manual.

Confidential Information - All information and documentation of a party to this Contract that: has been marked “confidential” or with words of similar meaning, at the time of disclosure by such party; 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, should reasonably be recognized as confidential information of the disclosing party. The term “Confidential Information” does not include any information or documentation that was: subject to disclosure under the Michigan Freedom of Information Act (FOIA); already in the possession of the receiving party without an obligation of confidentiality; developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party’s proprietary rights; obtained from a source other than the disclosing party without an obligation of confidentiality; or, publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party).

Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Enrollee survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers’ experiences with health care.

Contract - The State Medicaid Agency Contract (SMAC) developed by MDHHS pursuant to 42 CFR 422.107(c) to enter into with a Contractor that specifies the terms and conditions pursuant to which Contractor may operate in Michigan.

Contract Management Team (CMT) — MDHHS representatives responsible for overseeing contract management.

Contract Operational Start Date — The first date on which any Enrollment into Contractor’s HIDE SNP is effective.

Counties with Extreme Access Consideration (CEAC) – See Rural Area.

Cost Sharing Obligations - Financial payment obligations incurred by MDHHS 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 MDHHS 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”).

Coverage Decision Letter - Decision letter used by Contractor to provide notice of a denied item, service, or Part B drug, in whole or in part, or notice that a previously authorized course of treatment is reduced or discontinued. The Coverage Decision Letter must be substantially similar to the form available at https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements or as revised or amended by CMS. Coverage Decision Letters include Integrated Organization Determination notices as described herein.

Covered Services — The set of supports and services to be offered by Contractor as defined in Section IV.

Critical Incident - Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of an Enrollee, including Adverse Events and Provider Preventable Conditions as defined by the National Quality Forum.

Critical Incident Management – Contractor's policies and procedures regarding review and management of Critical Incidents and Adverse Events.

Cultural Competence – Understanding and being able to respond appropriately to values, beliefs, and needs that are associated with the Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care and supports and services to persons with congenital or acquired disabilities. A competency based on the premise of respect for the Enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

Current Dental Terminology Codes - A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefits plans.

Data Exchange System (DEX) – Web-based application used to identify providers who have been revoked from Medicare and terminated from states' Medicaid programs. DEX also provides the ability to search for providers and five percent (5%) or more owners listed in the Social Security Administration Death Master File. Data available in the DEX, including the former Medicare Exclusion Database, were previously housed in a server called TIBCO.

Days – Calendar days unless otherwise specified.

Dismissal – A dismissal includes a decision not to review a request for an Integrated Grievance, Integrated Appeal, or Integrated Organization Determination because it is considered invalid or does not otherwise meet the requirements for a request for Integrated Grievance, Integrated Appeal, or Integrated Organization Determination.

Dual Eligible - Any Medicare managed care recipient who is also eligible for Medicaid, and for whom MDHHS 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.

Dual Eligible Enrollee - A Dual Eligible who is eligible to participate in, and is voluntarily enrolled in, in Contractor's HIDE SNP.

Electronic Health Record (EHR) - Ability to electronically exchange eligibility and claim information with Providers.

Electronic Visit Verification System (EVV) - With respect to provision of Medicaid personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to (i) the type of service performed; (ii) the individual receiving the service; (iii) the date of the service; (iv) the location of service delivery; (v) the individual providing the service; and (vi) the time the service begins and ends.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Services – Inpatient and outpatient services covered under this Contract that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Encounter - A Medicare Part C covered service or group of covered services, as defined by the MA Agreement, or a Medicaid covered service 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.

Encounter Data - Medical records containing details for each enrollee encounter with a Provider for health services for which Contractor paid the Provider for Covered Services.

Enrollee – Any individual who is dually eligible who is currently enrolled with a Contractor including the duration of any month in which his/her eligibility for Contractor ends.

Enrollee Advisory Committee – Per 42 CFR 422.107(f), any MA organization offering one or more D-SNPs in Michigan is required to establish and maintain one or more enrollee advisory committees that serve the D-SNPs offered by the MA organization in Michigan. The Enrollee Advisory Committee composition reflects the diversity of Enrollees. At least one half of the Enrollee Advisory Committee includes a mix of Enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations, with one third of the Enrollee Advisory Committee composed of Enrollees.

Enrollee Communications - Materials designed to communicate plan benefits, policies, processes, and Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

Enrollee Medical Record - Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee's general health and well-

being, as well as any clinical information concerning illnesses and chronic medical conditions.

Enrollment - The processes by which a Potential Enrollee is enrolled into the HIDE SNP.

Enrollment Services Contractor - An entity contracted with MDHHS to contact and educate general Medicaid beneficiaries about managed care.

Exclusively Aligned Enrollment - Pursuant to 42 CFR 422.2, when the state policy limits a D SNPs membership to individuals with aligned enrollment, thus making all the D SNP's enrollees exclusively aligned either within the D NSP itself or with affiliated Medicaid plans.

Expedited Appeal –The accelerated process by which a Contractor must respond to an Appeal by an Enrollee if a denial of care decision by a Contractor may jeopardize life, health or ability to attain, maintain or regain maximum function.

External Appeal – An Appeal, subsequent to Contractor's Appeal decision, to the State Fair Hearing process for Medicaid-based Adverse Benefit Determination, or the Medicare process for Medicare-based Adverse Benefit Determination.

External Quality Review Organization (EQRO) – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by Contractors to their Enrollees.

Face-to-Face - An encounter that can be either in person or using telehealth (simultaneous audio and visual technology).

Federally-Qualified Health Center (FQHC) — an entity that satisfies the criteria set forth in 42 U.S.C. § 1396d(l)(2)(B); includes Rural Health Centers (RHCs) as defined in Section 1861(aa)(2) of the Social Security Act

First Tier, Downstream and Related Entity (FDR) — An individual or entity that enters into a written arrangement with Contractor, acceptable to CMS, and MDHHS to provide administrative or health care services of Contractor under this Contract.

Fraud - Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes Fraud under federal or State law.

Full Benefit Dual Eligible (FBDE) - An individual who 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, but who does not meet the income or resource criteria for QMB or SLMB. FBDEs are eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments.

Grievance - Any complaint or dispute, other than one that constitutes an Organization Determination, expressing dissatisfaction with any aspect of Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested. The term Grievance(s) as used in this Contract includes Integrated Grievances.

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, without limitation, an Enrollee's right to dispute an extension of time proposed by Contractor to make an authorization decision.

Habilitation Supports Waiver - 1915(c) home and community-based services waiver that provides intensive habilitation and support services to assist individuals with intellectual/developmental disabilities to live independently in the community.

Health Care Payment Learning & Action Network (LAN) - A public-private partnership dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Health Disparities - A particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

Health Equity - The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Health Insuring Corporation (HIC) – A corporation licensed by the State that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

Health Outcomes Survey (HOS) – Enrollee survey used by the Centers for Medicare & Medicaid Services to gather valid and reliable health status data in Medicare managed care

for use in quality improvement activities, plan accountability, public reporting, and improving health.

Health Plan Management System (HPMS) — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, Plan Benefit Packages, formularies, and other information via HPMS.

Health Related Social Needs (HRSN)- Health Related Social Needs, as defined by CMS, are an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying Social Determinants of Health.

Health Risk Assessment (HRA) – A comprehensive assessment of an Enrollee's medical, psychosocial, cognitive, and functional status to determine their medical, behavioral health, LTSS, and social needs.

Health Risk Assessment Tool (HRAT) – A broad assessment tool that will be used to assess the Enrollee's current health and functional needs within ninety (90) calendar days of Enrollment. This assessment will serve as the basis for further assessment needs that may include Long Term Supports and Services, Behavioral Health, Intellectual or Developmental Disability and/or Substance Use Disorder.

Healthcare Effectiveness Data and Information Set (HEDIS) — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

HIDE SNP Program Liaison - An individual employed by Contractor who is located in an operations/business office in Michigan and represents Contractor in all matters pertaining to Contractor, and acts as a link between Contractor, MDHHS, and CMS. This individual has the responsibilities set forth in this contract.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) - An integrated health plan that combines the benefits of Medicare and Medicaid from a managed care organization into a more unified care plan including Managed Long-Term Services and Supports. Medicaid Behavioral Health benefits are carved out to the Prepaid Inpatient Health Plans. Although less integrated than FIDE SNPs, HIDE SNPs still incorporate both behavioral health and Managed Long-Term Services and Supports benefits into the plan.

Home and Community-Based Services (HCBS) Waiver – A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more

of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (Nursing Facility) placement.

Hospital Access Agreement (HAA) - An agreement between MDHHS and the hospital that applies when a hospital provides services to Medicaid beneficiaries who are enrolled in a Contractor with which the hospital does not have a contract. Where a hospital and Contractor have a contract, the terms of that contract govern each relationship, and the HAA does not apply. When a hospital and a Contractor have a limited services contract, Contractor applies for all covered services outside the scope of the limited services contract. Since the HAA is not a contract between a hospital and Contractor, it is expected that health plans will continue to use network-contracted providers where appropriate.

In-Person - An encounter that must be completed with beneficiary and provider physically together in the same location and is not allowed through telehealth.

Independent Living Philosophy – A philosophy that emphasizes consumer control, the idea that people with disabilities are the best experts on their own needs, having crucial and valuable perspective to contribute and deserving of equal opportunity to decide how to live, work, and take part in their communities, particularly in reference to services that powerfully affect their day-to-day lives and access to independence.

Indian Enrollee – An Enrollee who is an Indian as defined at 25 USC 1603(13), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.

Indian Health Care Provider – A health care program, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603).

Individualized Care Plan (ICP) – The plan of care developed by an Enrollee, the Enrollee's HIDE SNP Care Coordinator and the Enrollee's Integrated Care Team which incorporates the following elements: assessment results; summary of the Enrollee's health; the Enrollee's preferences for care, supports and services; the Enrollee's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring and Reassessment; and the due date for the intervention and Reassessment. The ICP is also referred to as person-centered plan or plan of care. The ICP will be maintained in the Electronic Health Record along with evidence of the Enrollee's acceptance of the ICP including Enrollee and/or provider(s) signature when appropriate per ICP guidance.

Informal Supports - Assistance provided from various sources such as family, friends, colleagues, neighbors, and community members without any formal agreement or payment.

Integrated Appeal - The procedures that deal with, or result from, adverse Integrated Organization Determinations by Contractor on the benefits both under Part C and under state Medicaid rules the Enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Enrollee), or on any amounts the Enrollee must pay for a service. Integrated Appeals do not include appeals related to Part D benefits.

Integrated Appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an Appeal defined in 42 CFR §422.561 or the procedures required for appeals in accordance with 42 CFR §§438.400 through 438.424. Such procedures include, without limitation, Integrated Reconsiderations.

Integrated Care Organization (ICO) – A Health Insuring Corporation contracted with MDHHS and CMS to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the Enrollee.

Integrated Care Team (ICT) – A team including the Enrollee, Enrollee's chosen allies or legal representative, Primary Care Physician, HIDE SNP Care Coordinator, LTSS representative(s) or PIHP representative(s) as applicable and others as needed. The ICT works with the Enrollee to develop, implement, and maintain the ICP and to coordinate the delivery of services and benefits as needed for the Enrollee.

Integrated Grievance - A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under 42 CFR §422.564 or §§438.400 through 438.416. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in §422.564(b) and (c). An Integrated Grievance made by an Enrollee in an Applicable Integrated Plan is subject to the Integrated Grievance procedures in §§422.629 and 422.630. Integrated Grievances do not include Grievances related to Part D benefits.

Integrated Organization Determination - An Organization Determination that would otherwise be defined and covered, for a non-applicable integrated plan, as an organization determination under §422.566, an Adverse Benefit Determination under §438.400(b), or an action under 42 CFR §431.201. An Integrated Organization Determination is made by Contractor and is subject to the Integrated Organization Determination procedures in §§422.629, 422.631, and 422.634.

Integrated Reconsideration - A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a Reconsideration under §422.580 and Appeal under §438.400(b). An Integrated Reconsideration is made by Contractor and is subject to the Integrated Reconsideration procedures in 42 CFR §§422.629 and 422.632 through 422.634. Integrated Reconsiderations do not include Redeterminations related to Part D benefits.

Involuntary Disenrollment – Disenrollments under Section 2.9 of this Contract.

Large Metro – See Urban.

List of Excluded Individuals and Entities (LEIE) - The Office of Inspector General (OIG) maintains a list of all currently excluded individuals and entities called the LEIE. When the OIG excludes an individual or entity from participation in federally funded health care programs it includes that party's name, address, Provider type, and the basis for the exclusion in the LEIE. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the online database does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Long Term Care Reimbursement and Audit Division - The organizational area within MDHHS responsible for rate setting and reimbursement for Michigan's nursing facilities.

Long Term Supports and Services (LTSS) - A variety of supports and services that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

MA Agreement - 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.

MA-PD Plan - 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.

Marketing, Outreach, and Enrollee Communications — Any informational materials for current and prospective Enrollees that are consistent with the definitions and explanations in this contract and any related guidance documents.

MDHHS – The Michigan Department of Health and Human Services was formerly two departments: the Michigan Department of Community Health and the Michigan Department of Human Services.

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 Managed Care Organization (MCO) - A managed care organization that delivers health care benefits in an efficient, streamlined manner that emphasizes improving cost, utilization, and quality of care. Within Medicaid, MCOs establish contractual arrangements with state agencies to deliver health benefits and related services, based on an established rate of payment for those services and a set number of members receiving care within a month.

Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Michigan Department of Health and Human Services (Community Health Automated Medicaid Processing System - CHAMPS)

Medically Necessary Services – Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in their community.

Medicare — Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage - The Medicare managed care options that are authorized under Part C of Title XVIII of the Social Security Act and implementing regulations at C.F.R. part 422.

Medicare Election Period - A period of time when an Enrollee may change their Contractor, and/or return to Original Medicare.

Medicare Medicaid Assistance Program (MMAP) – MMAP is Michigan's State Health Insurance Program (SHIP) that assists individuals in understanding the Medicare and Medicaid programs and provides Enrollment assistance to persons seeking guidance on health care options.

Medicare-Medicaid Coordination Office (MMCO) - Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medication Review and Reconciliation – The review of a medication regimen (including prescribed medication, over-the-counter medications, and herbal supplements) to ensure it is appropriate for the individual, determine appropriate use, identify potential medication interactions, protect the individual against overmedication, and possibly educate and train family members or caretakers.

Metro – See Urban.

MI Choice – A Michigan Medicaid program authorized under 1915(c) authority that furnishes Home and Community-Based Services (HCBS) for individuals who are elderly or physically disabled. Individuals enrolled in MI Choice must disenroll from their existing program to participate in the HIDE SNP.

Michigan 1115 Behavioral Health Demonstration-The approved 1115 waiver through which Medicaid covered behavioral health services are provided for persons with serious and persistent mental illness and intellectual/developmental disabilities.

Michigan Compiled Laws (MCL) – The official codification of statutes for the State of Michigan.

Michigan Department of Insurance and Financial Services (DIFS) – The agency responsible for regulation of all insurers operating in the state of Michigan.

Micro – See Rural Area.

Minimum Data Set (MDS) — Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for Nursing Facility residents to return to community settings.

National Committee for Quality Assurance (NCQA) — A private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification, and recognition, e.g., health plan accreditation.

Notice – Communication provided to the Enrollee in written form.

Nursing Facility - Any facility licensed by the State of Michigan, in accordance with the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, and certified by Medicare in accordance with 42 C.F.R. § 483 et seq. to provide skilled and non-skilled nursing care.

Nursing Facility Care – Long term, skilled nursing or rehabilitation services provided in a facility licensed in accordance with MCL 333.1101 – 333.25211 and certified in accordance with 42 C.F.R.§ 483 et seq. designed to meet an Enrollee's needs.

Nursing Facility Level of Care Determination (LOCD) - The assessment tool utilized in determining if an Enrollee meets medical and functional eligibility for Medicaid-reimbursed Nursing Facility Care, or Enrollment in the MI Choice Program, HIDE D-SNP, HCBS Waiver, or Program of All-Inclusive Care for the Elderly (PACE). The LOCD is an electronic web-based system accessed through CHAMPS.

Ombudsman - The entity designated by the State, and independent of the MDHHS, that advocates and investigates on behalf of Enrollees to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the MICH program as provided for in State administrative rules and in accordance with the Older Americans Act of 1965.

Organization Determination - As defined in 42 CFR §422.566 Medicare Advantage Program, Grievances Organization Determinations and Appeals, Organization Determinations, any determination made by Contractor with respect to any of the following:

Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

Payment for any other health services furnished by a provider other than Contractor that the Enrollee believes—

Are covered under Medicare; or

If not covered under Medicare, should have been furnished, arranged for, or reimbursed by Contractor.

Contractor's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Enrollee believes should be furnished or arranged for by Contractor.

Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.

Failure of Contractor to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the Enrollee.

Patient Pay Amount (PPA) - The amount the Enrollee must pay toward the cost of Medicaid covered Nursing Facility Care as determined by the local Michigan Department of Health and Human Services office.

Patient's Right to Independent Review Act (PRIRA) - A Michigan law that provides patients with appeal rights due to adverse decisions made by health carriers regarding a denial, reduction, or termination of health care services. The PRIRA external review process applies after the patient has exhausted the health carrier's internal grievance process.

Person-Centered Planning Process – A process for planning and supporting a person receiving services that builds on the individual's desire to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The Person-Centered Planning Process is led by the person and involves families, friends, legal representative, and professionals as they desire or requires. The process must be conducted in person unless the Enrollee declines the opportunity to participate in person.

Plan Benefit Package (PBP) - Medicare Part A and Part B and supplemental benefits being offered by a plan. This information includes benefit description, maximum plan-benefit coverage, Maximum Out-of-Pocket (MOOP) costs for enrollees, coinsurance, deductible, copayments, authorizations, and referrals.

Post-Stabilization Care Services - Covered Services related to an Emergency Medical Condition that are provided after the Enrollee's Emergency Medical Condition has been Stabilized to maintain the Stabilized condition and/or under the circumstances described in 42 C.F.R. § 438.114(e).

Potential Enrollee — An individual who is eligible to enroll in the HIDE SNP but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and are receiving full Medicaid benefits, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria.

Pre-Eligibility Medical Expenses (PEME) – Costs that an individual may incur before they become eligible for Medicaid benefits. These expenses are considered in determining eligibility for Medicaid and can include medical expenses that exceed the deductible amount.

Pre-paid Inpatient Health Plan (PIHP) – PIHPs manage the Medicaid specialty services under the Michigan 1115 Behavioral Health Demonstration, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance

use services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and supports, or substance use services.

Prevalent Languages — Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.

Preventative Dental Services - General dental examinations consisting of preventive services, which include routine maintenance cleaning with oral hygiene instruction limited to once every six (6) months.

Primary Care Provider (PCP) – Practitioner of primary care selected by the Enrollee or assigned to the Enrollee by Contractor and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be advanced practice registered nurse, nurse practitioners, physician assistants or physicians who are board certified, or a specialist selected by an Enrollee.

Privacy Rules - Requirements established in the Privacy Act of 1974, Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant Michigan privacy laws.

Program of All-Inclusive Care for the Elderly (PACE) — A capitated benefit for frail elderly who meet the State's criteria for LOCD authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, Michigan, and the PACE organization. PACE participants must disenroll from their existing program to participate in Contractor.

Provider Contract - A written agreement between Contractor and a Provider for the provision of services under the Agreement.

Provider Network – The collective group of Network Providers who have entered into Provider Contracts with Contractor for the delivery of MCO Covered Services. This includes, but is not limited to, physical, behavioral, pharmacy, and ancillary service providers.

Provider Preventable Condition - A hospital acquired condition or a condition occurring in any health care setting that has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the Enrollee, and is auditable. Provider preventable conditions include serious reportable events.

Qualified Disabled and Working Individual (QDWI) - 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.)

Qualifying Individuals (QI) - 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.)

Qualified Medicare Beneficiary (QMB) - 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:

• QMB

• 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.

Quality Assurance Supplement (QAS) - Supplemental payment made to nursing facilities that incorporates funds from the quality assurance assessment tax as approved in the Michigan state plan.

Quality Improvement Committee (QIC) - The QIC reviews Contractor QAPI program, its results and activities, and recommends changes on an ongoing basis.

Quality Improvement Organization (QIO) – As set forth in Section 1152 of the Social Security Act and 42 C.F.R. Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

Rapid Dispute Resolution Process - The process implemented by MDHHS to administer and resolve Claim disputes.

Readiness Review – A process that will evaluate each MA Health Plan's ability to comply with contract requirements, including but not limited to, the ability to process Medicaid Claims (including LTSS claims) and Enrollment information, accept and transition new Enrollees, assess and coordinate care, and provide adequate access to all Medicaid-

covered services and service delivery methods, including self-directed arrangements, under this contract quickly and accurately. MDHHS will use the results to inform the decision of whether the MA Health Plan is ready to participate as a HIDE SNP. At a minimum, the Readiness Review will include a desk review and may include a site visit to the MA Health Plan's Michigan offices.

Reassessment – A detailed assessment of the Enrollee at specified intervals, after a change in health status or at the Enrollee's request.

Rural Area - A Census designated area outside of a metropolitan statistical area. The Census defines "rural" as micro, rural, and counties with extreme access considerations (CEAC) areas.

Self-Determination – An option that allows an Enrollee to direct and control personal care services and certain HCSB waiver services by identifying, accessing, and managing supports and services in accordance with their needs and personal preferences. Arrangements that support Self-Determination means that the Enrollee has the authority to exercise decision making over LTSS and accepts the responsibility for taking a direct role in managing them. Arrangements that support Self-Determination are an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the service plan developed through the Person-Centered Planning Process. Self-Determination promotes personal choice and control over the delivery of LTSS, including who provides services, how they are delivered, and hiring and firing personal attendants and/or home care workers. This option may also be referred to as self-direction.

Self-Direction - See definition of Self-Determination

Serious Reportable Event – A serious, largely preventable, and harmful clinical event, as defined by the National Quality Forum. Also referred to as an Adverse Event.

Service Area - The specific geographic area of Michigan designated in the CMS HPMS, and as referenced in Appendix B, for which Contractor agrees to provide Covered Services to all Enrollees.

Single Case Agreement – An agreement between Contractor and a non-network provider to treat an Enrollee at the applicable Medicaid or Medicare fee for service (FFS) rates.

Social Determinants of Health - also referred to as Social Drivers of Health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social Determinants of Health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Solvency – Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by MDHHS and agreed to by CMS.

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 exceed twice the SSI limit. Categories of SLMBs covered by this Contract are:

• SLMB

• 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.

Stabilized - As defined in 42 C.F.R. § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

State – The State of Michigan, including without limitation, any departments, divisions, agencies, offices, commissions, officers, employees, and agents.

State Data – 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 Enrollee, such as an Enrollee'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) PHI collected, used, processed, stored, or generated as the result of the Contract activities, which is defined under HIPAA and its related rules and regulations.

State Fair Hearing – An impartial review of a decision made by the MDHHS or one of its contract agencies which is conducted by a Michigan Office of Administrative Hearings and Rules (MOAHR) Administrative Law Judge under the oversight, supervision, and authority of MDHHS, so as to provide due process rights required by applicable law and consistent with 42 C.F.R. §431 subpart E.

State Plan - the State of Michigan's plan for the Medical Assistance Program as submitted by MDHHS 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.

State Plan Personal Care - Services provided for in the Michigan State Plan that address physical assistance needs and enable individuals to live in their homes. Personal care services include hands-on assistance with activities of daily living (ADLs): eating, toileting, bathing, grooming, dressing, ambulation and transferring and instrumental activities of daily living (IADLs): personal laundry, light housekeeping, shopping, meal preparation and medication administration. Services are also provided to qualifying beneficiaries living in adult foster care or home for the aged settings by way of a personal care supplement payment made to the provider to support ADL and IADL needs of residents.

Subcontract - an agreement 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.

Teletypewriter (TTY) – a teleprinter, an electronic device for text communication over a telephone line, that is designed for use by persons with hearing or speech difficulties. Another name for the device is teletypewriter (TTY).

Third Party Marketing Organization (TPMO) – As defined in 42 CFR §2260 as it may be amended from time to time.

Transition Agency - Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations that have a contract with MDHHS to coordinate and deliver Community Transition Services.

Treating Provider – Someone who provides or has provided clinical treatment or evaluation to the Enrollee and who has, or has had, an ongoing treatment relationship with the Enrollee within the past (twelve) 12 months. Generally, an ongoing treatment relationship is considered to be when the clinical evidence establishes that the Enrollee sees, or has seen, the provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation and/or service required for clinical need(s). Treating Providers include primary care physicians, specialists, physician assistants, advanced practice registered nurse, psychiatrists, counselors, and therapists. Treating Providers are not those who provide services that are non-clinical in nature like chore services or provide only routine preventative care like preventive dental.

Utilization Review Accreditation Commission (URAC) – Medicare plan accreditation organization. Medicare plans that meet URAC's standards are recognized by CMS as complying with federal regulatory requirements related to their Part C coverage.

Urban Area - Metro and large metro areas. Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

Urgent Care — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result

of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.

pr(UM) - The process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.

Appendix B- Contractor Service Area

Contractor Medicare Plan ID and PBP #: _____

HIDE SNP Region	**2026-2033**
Region 1 Upper Peninsula	
Region 2 Northwest	
Region 3 Northeast	
Region 4 West Central	
Region 5 East Central	
Region 6 The Thumb	
Region 7 Central	
Region 8 Southwest	
Region 9 South Central	
Region 10 Macomb	
Region 11 Oakland County	
Region 12 Wayne County	

Appendix C – Medicaid Network Standards

HIDE SNP NETWORK ADEQUACY STANDARDS

MAXIMUM TIME AND DISTANCE AND RATIO STANDARDS

Maximum Time and Distance, and Ratio Standards
Time is measured in minutes and distance is measured in miles.

	Large Metro		**Metro**		**Micro**		**Rural**		**Counties with Extreme Access Considerations**		**All**
Medicaid Service Type	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Minimum Provider to Enrollees Ratio**
Dentistry: General Dentist	30	15	30	30	30	30	40	40	120	120	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
Dentistry: Endodontics	30	15	60	60	60	60	120	120	120	120	
Dentistry: Oral Surgery	30	15	60	60	60	60	120	120	120	120	
Dentistry: Periodontics	30	15	60	60	60	60	120	120	120	120	
Dentistry: Prosthodontics	30	15	60	60	60	60	120	120	120	120	
Audiology Services - Examinations	30	15	30	30	30	30	40	40	120	120	
Audiology Services - Hearing Aids	30	15	30	30	30	30	40	40	120	120	
Vision Services - Eye Examinations	30	15	30	30	30	30	40	40	120	120	
Vision Services - Eye Wear	30	15	30	30	30	30	40	40	120	120	
Adult Day Care	30	30	30	30	30	30	40	40	60	60	
Skilled Nursing Facility	20	10	45	30	80	60	75	60	95	85	

To be counted in the General Dentistry 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).

HIDE SNP NETWORK ADEQUACY STANDARDS - LTSS TIMELY ACCESS STANDARDS

LTSS Timely Access Standards **Timely Access is measured in calendar Days.**					
LTSS Provider & Service Type	**Length of Time from Authorization to Initiation of Service**				
	Large Metro	**Metro**	**Micro**	**Rural**	**Counties with Extreme Access Considerations**
Adaptive/Enhanced Durable Medical Equipment and Supplies	21			28	
Assistive Technology Devices	21			28	
Chore Services	14			21	
Community Living Supports	7			14	
Home Delivered Meals	14			21	
Personal Care Services - Non-Waiver	7			14	
Personal Emergency Response System	30			30	
Preventive Nursing Services (non-agency and agency)	7			14	
Private Duty Nursing (non-agency and agency)	7			14	
Respite	7			14	
	7			14	
Vehicle Modifications	90			120	

HIDE SNP NETWORK ADEQUACY STANDARDS - TIMELY ACCESS STANDARDS

Timely Access Standards	
Type of Care/Appointment	**Length of Time**
Specialty Care, such as Vision & Hearing	Within six (6) weeks of request
Acute Specialty Care, such as Vision & Hearing	Within five (5) Business Days of request
Emergency Dental Services	Immediately 24 hours/day 7 Days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within twenty-one (21) Business Days of request
Preventive Dental Services	Within six (6) weeks of request

Initial Dental Appointment	Within eight (8) weeks of request

Appendix D - Behavioral Health

Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid

Contractor must utilize the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid located in the link below:

Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid

This grid indicates HIDE SNP and Prepaid Inpatient Health Plan (PIHP) coverage responsibility for behavioral health services. It should be utilized by Contractor, to determine the responsible entity for authorization and payment of behavioral health services delivered to Enrollees.

The grid currently delineates coverage responsibility by the setting in which a service is provided. MDHHS intends to modify this policy and grid so that coverage responsibility for mental health services will be determined by the level of Enrollees' needs rather than by the setting in which a service is provided. The grid will be updated in accordance with any change in MDHHS policy.

In addition to this grid, Contractor should follow Medicaid policy as described in the Medicaid Provider Manual and the entity's contract with the State and as directed by MDHHS.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral and Physical Health and Aging Services Administration
PIHP-HIDE-SNP Model Agreement

Coordinating Agreement Between
<PIHP> and <HIDE-SNP>
For the County(ies) of: <X>

<DATE>

This agreement is made and entered into this __ day of ____, in the year____ by and between _____ (PIHP) and _____ (HIDE-SNP) for the County(ies) of X, Y, Z.

RECITALS

Whereas, the Prepaid Inpatient Health Plans (PIHPs) manage the 1115 Behavioral

Health Demonstration Waiver Program, the Healthy Michigan Plan, and relevant approved Waivers, to provide a comprehensive array of specialty mental health and substance use disorder services and supports under contract with the Michigan Department of Health and Human Services (MDHHS) consistent with the Michigan Mental Health Code (MMHC); and

Whereas, the PIHPs manage the Medicaid Specialty Services and Supports Contract in a specified geographic region and;

Whereas, the Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) are contracted with MDHHS to coordinate the delivery of Medicare and Medicaid benefits for individuals who are eligible for such services and enrolled in the HIDE-SNP, and provide coverage of Medicaid services, including long-term services and supports and behavioral health services not otherwise provided by a PIHP for individuals eligible for such services; and

Whereas, MDHHS expects and the PIHPs and the HIDE-SNPs desire to coordinate and collaborate their efforts in order to protect and promote the health of the Mutually Served Enrollee population.

The PIHP and the HIDE-SNP agree as follows:

A. Definitions

HIDE-SNP means Highly Integrated Dual Eligible Special Needs Plan.

MDHHS means the Michigan Department of Health and Human Services.

Mutually Served Enrollee means an Enrollee that is dually eligible for Medicare and Medicaid, actively enrolled in the HIDE-SNP, and being assessed for, is eligible for, or is receiving, Medicaid Specialty Behavioral Health services covered by the PIHP.

PIHP means Prepaid Inpatient Health Plan.

B. Roles and Responsibilities

The parties acknowledge that the primary guidance concerning their respective roles and responsibilities stem from the following, as applicable:

- Medicaid Waivers
- Medicaid State Plan and Amendments
- Medicaid Provider Manual (MPM)
- Contractual agreements between MDHHS, the PIHP and the HIDE-SNPs.
- MDHHS Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid L-Letter 10-21 - Current Version

C. Terms of Agreement, Amendments, and Cancellation

This Agreement is effective the date upon which the last party signs this Agreement until amended or cancelled. The Agreement is subject to amendment due to changes in the contracts between the MDHHS and the PIHP or the HIDE-SNP. All Amendments shall be executed in writing. Either party may cancel the agreement upon thirty **(30) days** written notice.

Nothing in this Agreement shall be interpreted to preclude deeper and broader Plan to Plan efforts, processes, and arrangements with or without monetary value exchange. Such arrangements shall be made in writing in separate agreement(s).

D. Purpose

The purpose of this Agreement is to address the coordination of physical and mental health services provided by the PIHP and the HIDE-SNP for Mutually Served Enrollees.

Specifically, the goal is to improve Mutually Served Enrollees' health status, improve the Mutually Served Enrollees' experience of care, and to reduce unnecessary costs.

E. Areas of Shared Responsibility

1. Administration, Point of Authority, Communication:

    a. The PIHP and the HIDE-SNP designate below the respective persons who have authority to administer this Agreement on behalf of the PIHP and the HIDE-SNP:

    [PIHP Name, Address, Phone, Signatory, and Agreement Authority with Contact Information]

    [HIDE-SNP Name, Address, Phone, Signatory, and Agreement Authority with Contact Information]

    b. The PIHP and the HIDE-SNP will establish, in writing, key contact personnel for ongoing HIDE-SNP – PIHP communication and coordination.

    c. The PIHP and the HIDE-SNP shall inform the other in writing of current contact information for their respective enrollee service and other related plan departments.

2. Exchange of Information:

    a. The parties will use a combination of their enrollment files, the 270/271 enrollment and eligibility verification process, CHAMPs, and MDHHS CareConnect360 system to access the list of Mutually Served Enrollees and their respective information.

    b. The parties shall begin and maintain Mutually Served Enrollee information exchange efforts and healthcare data analytics. If protected and/or confidential Mutually Served Enrollee information are to be exchanged, such exchanges shall be in accordance with all applicable federal and state statutes and regulations. The parties shall ensure that the MDHHS-5515 standard release form will be accepted, honored, and used, according to the provisions of Public Act 129 of 2014 and MSA 18-44.

    c. Prior to exchanging any Mutually Served Enrollee information, the parties, and any relevant subcontractors or providers, shall obtain a release of information authorization from the Mutually Served Enrollee as required by

federal and state law unless information exchange is otherwise permitted for the sharing of health records for purpose of treatment, payment, operations, and care coordination.

d. Disputes regarding data sharing will be settled using the Dispute Resolution process in Section G.

3. Referral Procedures:

a. The PIHP shall exercise reasonable efforts to assist Mutually Served Enrollees in understanding the role of the HIDE-SNP and how to contact the HIDE-SNP.

b. The HIDE-SNP shall exercise reasonable efforts to assist Mutually Served Enrollees in understanding the role of the PIHP and how to contact the PIHP.

c. The PIHP and HIDE-SNP shall both encourage and maintain Plan to Plan and Plan to Primary Care Physician (PCP) communications and collaborations.

d. Each party shall exercise reasonable efforts to rapidly determine and provide the appropriate type, amount, scope, and duration of medically necessary services as guided by the MPM.

e. The HIDE-SNP will make referral to the PIHP for an assessment for SUD, BH Needs, or I/DD needs, as quickly as the Mutually Served Enrollee's needs require, and no longer than within five (5) calendar days from the date the need for an assessment was identified and in accordance with the requirements of the HIDE-SNP's contract with MDHHS.

f. The PIHP must make best efforts to conduct necessary BH assessments, as quickly as the Mutually Served Enrollee's needs require, in accordance with the requirements of the PIHP's contract with MDHHS, and no longer than within 15 calendar days of receiving a referral from a HIDE-SNP.

g. When making a referral to a PIHP or it's subcontractor(s), the HIDE-SNP must communicate with the PIHP who is receiving the referral to let them know they are about to refer the Mutually Served Enrollee. The PIHP team should be supplied with the relevant background information, including any Social Determinants of Health (SDOH) screening, and should have the necessary expertise to assist the Mutually Served Enrollee.

h. Each party agrees to track referrals and conduct further outreach to Mutually Served Enrollees, and/or the HIDE-SNP and the PIHP, or their contracted behavioral health providers, if necessary.

i. Each party shall develop, provide, and update specific written behavioral health referral processes and contacts. Each party shall develop and maintain process for multi-lateral referral tracking and service access metrics.

4. Medical and Care Coordination; Emergency Services; Pharmacy and Laboratory Services Coordination; Quality Assurance Coordination:

   a. Each party shall exercise reasonable efforts to support the Mutually Served Enrollee and systemic coordination of care. The parties shall explore and consider the prudence and cost-benefits of systemic and Mutually Served Enrollee focused care coordination efforts. Care coordination efforts should involve the exchange of Mutually Served Enrollees' health information, including Long Term Services and Supports (LTSS). The exchange shall be in accordance with applicable federal and state statutes and regulations related thereto. Each party shall make available to the other contact information for case level medical and care coordination.

   b. Neither party shall withhold emergency services, and each party shall resolve payment disputes in good faith.

   c. Each party shall take steps to reduce duplicative pharmacy and laboratory services and agree to abide by L-Letter 10-21: The MDHHS Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid - Current Version, and other related guidance for payment purposes.

   d. Each party agrees to consider, and may implement by mutual agreement, Quality Assurance Coordination efforts, including initiating jointly developed clinical Performance Improvement Project(s) to measure improved outcomes of Mutually Served Enrollees.

   e. Integrated Care Team (ICT): The PIHP coordinator is responsible for coordination of Medicaid Specialty Behavioral Health Services with the HIDE-SNP for other services. The HIDE-SNP will invite the PIHP coordinator to participate in the ICT. Each party can invite additional staff, and/or relevant subcontractors or providers, to participate, as necessary.

f. The Parties shall develop and maintain active processes to monitor, report and jointly intervene to improve individual metrics for Mutually Served Enrollees, including HEDIS metrics.

g. The parties shall coordinate care with Peer Support Specialists, Peer Recovery Coaches, and/or Community Health Workers (CHWs), as appropriate, to coordinate care between providers, including but not limited to, PCPs and Community Mental Health Service Providers (CMHSPs).

F. Appeal and Grievance Resolution

Each party agrees to fulfill its Mutually Served Enrollee rights and protections as well as appeal and grievance obligations with Mutually Served Enrollees and to coordinate resolutions as necessary and appropriate.

G. Dispute Resolution

Each party shall not permit uncertainty or dispute over services or responsible payer to interfere with Mutually Served Enrollee service access.

The parties specify below the steps that each shall follow to dispute a decision or action by the other party related to this Agreement:

1) Submission of a written request to the other party's Agreement Administrator for reconsideration of the disputed decision or action. The submission shall reference the applicable Agreement section(s), known related facts, argument(s), and proposed resolution/remedy; and

Where the dispute affects a Mutually Served Enrollee's current care, good faith efforts will be made to resolve the dispute with all due haste, and the receiving party shall respond in writing within **three (3) business days**.

Where the dispute is regarding an administrative or retrospective matter, the receiving party shall respond in writing within **thirty (30) business days**.

H. Governing Laws

Both parties agree that performance under this Agreement will be conducted in compliance with all applicable federal, state, and local statutes and regulations. Where federal or state statute, regulation, or policy is contrary to the terms and conditions herein, statute, regulation, and policy shall prevail without necessity of amendment to this Agreement.

I. Merger and Integration

This Agreement expresses the final understanding of the parties regarding the obligations and commitments which are set forth herein, and supersedes all prior and contemporaneous negotiations, discussions, understandings, and agreements between them relating to the services, representations, and duties which are articulated in this Agreement.

J. Notices

All notices or other communications authorized or required under this Agreement shall be given in writing, either by personal delivery or by certified mail (return receipt requested). A notice to the parties shall be deemed given upon delivery or by certified mail directed to the addresses shown below:

Address of the PIHP:

_____

_____

_____

Attention: _____

Address of the HIDE-SNP:

_____

_____

_____

Attention: _____

K. Headings

The headings contained in this Agreement have been inserted and used solely for ease of reference and shall not be considered in the interpretation or construction of this Agreement.

L. Severability

In the event any provision of this Agreement, in whole or in part (or the application of any provision to a specific situation), is held to be invalid or unenforceable, such provision

shall, if possible, be deemed written and revised in a manner which eliminates the offending language but maintains the overall intent of the Agreement. However, if that is not possible, the offending language shall be deemed removed with the Agreement, otherwise remaining in effect, so long as doing so would not result in substantial unfairness or injustice to either of the parties. Otherwise, the party adversely affected may terminate the Agreement immediately.

M. No Third-Party Rights

Nothing in this Agreement, express or implied, is intended to or shall be construed to confer upon, or to give to, any individual or organization other than the parties, any right, remedy, or claim under this Agreement as a third-party beneficiary.

N. Assignment

This Agreement shall not be assigned by any party without the prior written consent of the other party. This Agreement shall survive any corporate or business merger of any Party.

O. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute the one in the same instrument.

P. Signatures

The parties, by and through their duly authorized representatives, have executed and delivered this Agreement. Every individual signing this Agreement on behalf of a party represents that he/she has full authority to execute and deliver this Agreement on behalf of that party with the effect of binding the party.

IN WITNESS WHEREOF, the parties hereto have entered in to, executed, and delivered this Agreement as of the day and year first written above.

PIHP

By: _____

Its: _____

Date: _____

HIDE-SNP

By: _____

Its: _____

Date: _____

Appendix E - Health Plan Obligations

HEALTH PLAN OBLIGATIONS

(To be included as an Appendix to the State's Medicaid Contract with Health Plans)

This obligation will apply where a Health Plan does not have a contract with a Hospital to provide services to the Health Plan's Medicaid beneficiaries and where Hospital has signed a Hospital Access Agreement with the Michigan Department of Community Health ("Department").

The Health Plan will make efforts to utilize network-contracted services where appropriate.

The Health Plan may deny any claims submitted later than 180 days from the date of service for the first year of this agreement and 120 days the second year and thereafter. The submission requirement will not apply in the event of exceptions that extend the time period. Exceptions granted by the Health Plan may be for changes in eligibility, coordination of benefits, other third-party payer issues, internal Hospital risk management, or other valid reasons which may have delayed the submission of a claim.

When the Hospital requests a billing extension, the Health Plan agrees to evaluate the information supplied and provide the Hospital with an extension when appropriate based on exceptions noted above. Under no circumstances will the Health Plan accept any claim that is submitted more than 365 days from the date of service.

Authorization Requests—Post Stabilization

The Hospital will make and document all post-stabilization authorization inquiries by telephone call to the Enrollee's Health Plan. The Health Plan will return all post-stabilization inquiries within one hour of receipt of the telephone call from the Hospital and the Hospital will not be required to make more than one call provided that the "one phone call" included clinical information. **Authorization for admission and additional services must be automatic should the Health Plan fail to respond within one hour**. The Hospital agrees to provide the Health Plan with requested information obtained from a "medical screening examination," provided in accordance with EMTALA, in order to determine the emergent status for payment approval, prior to treatment and after stabilization. The Health Plan must provide twenty-four (24) hour, seven (7) day a week availability for post-stabilization authorization requests.

Disputed Claims

Each Health Plan and Hospital that serves or has a contract to serve the same population of Medicaid beneficiaries will establish an Accounts Receivable Reconciliation Group

(ARRG) comprised of persons empowered to make decisions regarding outstanding bills and payments. The ARRG must reconcile accounts receivable of the Hospital with accounts payable of the Health Plan. These groups will minimally meet no less than every 90 days.

Claims in dispute by either the Hospital or the Health Plan will be forwarded to the Accounts Receivable Reconciliation Group. The group can table claims in question for one 90-day period before either resolving the claim or referring it to the Rapid Dispute Resolution Process. If agreement cannot be reached on the payment after review by the ARRG, the Hospital or Health Plan may pursue dispute resolution as set forth in the Rapid Dispute Resolution Process. If either the Hospital or Health Plan pursues Rapid Dispute Resolution Process, that determination is then binding on the other party. The claims forwarded to the Rapid Dispute Resolution Process may either be a single claim or may be a group of similar claims. The determination of claim similarity will be made by the mediator during the Rapid Dispute Resolution Process.

Payment

Forty-five Day Payment. The Health Plan must pay Hospital's Clean Claims within forty-five (45) days after receipt.

Thirty-Day Denial/Additional Information Notice. The Health Plan must provide the Hospital with a denial or written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient claim. The Health Plan may either deny the claim or make payment in full to the Hospital within thirty (30) days on a "corrected" claim.

Adjusted Payment. The Health Plan may make an Adjusted Payment on a submitted claim within forty-five (45) days after receipt, where the totality of circumstances do not support the billing criteria for the level of service submitted on the claim, and may remit or recover such Adjusted Payment, providing a full and complete explanation and remittance advice. Where such Adjusted Payment is made, the Hospital may dispute the adjustment, and pursue any and all remedies, including the Rapid Dispute Resolution Process or OFIS appeal process, or other remedies of law.

Payment and Remedies. Payment for services by a Health Plan must be made as set forth in this document, and any disputed claim aged over 90 days must give rise to the right of the Hospital to pursue the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process. Any award rendered pursuant to the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process must be made by the Health Plan within 30 days after its receipt of a final decision or withheld by MDHHS from the Health Plan's capitation and paid to the Hospital within 30 days after MDHHS's receipt of a final decision.

Rates. The Health Plan must pay the Hospital according to Medicaid Rates.

Post Payment Review. The Health Plan may implement a post-payment claim review process in accordance with Department policies.

Department Payment

The Department will deduct from future capitations and make payment to the Hospital for provision of Covered Services under the following conditions:

The Health Plan does not pay the Hospital the amount to which the Hospital is entitled for services described in "Provision of Covered Services" (Section 1.1 of Hospital Access Agreement, Attachment A) at the time such payment is required to be paid; and

The disputed claim has been reviewed by the Accounts Receivable Reconciliation Group, (ARRG) described above, and the Hospital has either, (i) forwarded the disputed claim to the Rapid Dispute Resolution Process (Attachment C) mediator, (ii) initiated an OFIS appeal process, or (iii) initiated another applicable legal process; and

A final decision that the Hospital is entitled to payment has been rendered through either the Rapid Dispute Resolution Process, the OFIS appeal process, or other applicable legal process; and

The Health Plan does not pay the disputed claim within 30 days of its receipt of the final decision.

Data Coordination

The Health Plan and the Hospital will share enrollee information in order to support claims payment administration, to enable coordination of benefits, subrogation, verification of coverage, prior authorization and record keeping.

Quality, Utilization and Risk Management (Q/U/RM)

The Health Plan and Hospital must coordinate Q/U/RM services required in connection with patient care to the extent required by applicable state and federal law or accrediting entities. The Health Plan must acknowledge that the information it receives as a result of participating in Q/U/RM activities with the Hospital is, and must remain, confidential as required by applicable law, and is furnished to the Health Plan solely to assist the Health Plan in conducting its own professional practice review. The Health Plan will reimburse the Hospital for reasonable photocopy expenses incurred by the Hospital in conducting the Q/U/RM review. The Health Plan may disclose confidential Q/U/RM information to third parties as necessary to (i) satisfy mandatory governmental or regulatory reporting requirements, (ii) for HEDIS reporting, (iii) for reporting required by applicable accrediting bodies.

Orderly Transfer

The Health Plan must cooperate with the Hospital in the orderly transfer of Enrollees being treated or evaluated to a contracted Hospital provider, in the event that the Plan or physician elects to transfer the Enrollee to another Hospital facility. In the event that services or care are required for any Enrollee while awaiting transfer, or within the context of preparation for the transfer, the Health Plan and the Hospital agree to share such information as may be required. The Health Plan must authorize payment for services, such as observation costs, in order to facilitate the orderly transfer and maintain the stability and health of the Enrollee. To the extent practicable, transfers to other hospitals should occur within 24 hours of the request of the Health Plan to the extent practicable.

Appendix F – Quality Measures

Quality Measures	Frequency	Report directly to MDHHS
HEDIS + HOS	Annually	Yes – As Requested.
Adult CAHPS	Annually	Yes – As Requested.
Lifetime Hepatitis C Screening	Annually	Yes – As Requested.
Hepatitis C Treatment	Annually	Yes – As Requested.
Care Coordination		
Members with an Individualized Care Plan completed within 90 days of enrollment	Quarterly	Yes
Members with first follow-up visit within 30 days of hospital discharge	Annually	Yes
MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls	Annually	Yes
Utilization		
Ambulatory care-sensitive condition hospital admission	Annually	Yes
Dental		
Annual Dental Visit	Annually	Yes
Diagnostic Dental Services	Annually	No
Preventive Dental Services	Annually	No
Restorative Services	Annually	No
Rebalancing + LTSS		
MLTSS-6: Long-Term Services and Supports Admission to a Facility from the Community	Annually	Yes
MLTSS-7: Long-Term Services and Supports Minimizing Length of Stay	Annually	Yes
MLTSS-8: Long-Term Services and Supports Successful Transition after Long-Term Facility Stay	Annually	Yes
Nursing facility residents experiencing one or more falls with a major injury.	Quarterly	No
Organizational Structure and Staffing		
Care Coordinator Caseload Limit	Monthly	Yes
Care Coordinator Turnover	Annually	Yes
Care Coordinator training for supporting self-direction	Annually	Yes

Appendix G - Quality Withhold Measures

Quality Withhold Measures	CY 2026
Members with an Individualized Care Plan completed within 90 days of enrollment	
Members with documented discussions of care goals	
Annual Dental Visit	
Encounter Timeliness and Completeness	

Appendix H – CMS County Designation Descriptions

Large Metropolitan ("Large Metro"): Unless otherwise indicated in this Contract, Large Metropolitan (or Large Metro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.

Metropolitan ("Metro"): Unless otherwise indicated in this Contract, Metropolitan (or Metro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.

Micropolitan ("Micro"): Unless otherwise indicated in this Contract, Micropolitan (or Micro) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.

Rural: Unless otherwise indicated in this Contract, a Rural County refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget."

Counties with Extreme Access Considerations (CEAC): Unless otherwise indicated in this Contract, Counties with Extreme Access Considerations (or CEAC) refers to a CMS county-based geographic designation. CMS' county type designations are based on the population size and density parameters of counties, as specified by the U.S. Census Bureau and U.S. Office of Management and Budget.

CMS periodically updates county designations. Contractor must ensure that current county designations are being used.

Appendix I – Enrollee Rights

Enrollee Rights

The HIDE SNP must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees.

Enrollees must be notified of these rights and protections at least annually, and in a manner that takes into consideration cultural considerations, Functional Status and language needs.

Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. and §422 Subpart C.

Specifically, Enrollees must be guaranteed:

The right to be treated with dignity and respect.

The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

The right to be provided a copy of their medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or Claims history, mental or physical disability, genetic information, or source of payment.

The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

The right to choose a plan and provider at any time in accordance with parameters defined in Regulation, Policy, and this Contract.

The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this Contract.

The right to participate in all aspects of care, including the right to refuse treatment, and to exercise all rights of Appeal.

Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end.

Specifically, Enrollees must:

Receive a Health Risk Assessment upon Enrollment in a plan and to participate in the development and implementation of the Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's goals, preferences, strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or authorized representative, also have the right to request a Reassessment by the Integrated Care Team and be fully involved in any such Reassessment.

Receive complete and accurate information on their health and functional status by the Integrated Care Team.

Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration the Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

Before Enrollment

At Enrollment

At the time an Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Enrollee to make an informed choice

Be encouraged to involve caregivers or family members in treatment discussions and decisions.

Have Advance Directives explained and to establish them, if the Enrollee so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.

Receive reasonable advance Notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the Enrollee's language and culture, and in an appropriate care setting, including the home and community.

The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Each Enrollee is free to exercise their rights and that the exercise of those rights does not adversely affect the way the HIDE SNP and its providers or the State Agency treat the Enrollee.

The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive Notice of any significant change in the information provided in the orientation materials at least thirty (30) calendar days prior to the intended effective date of the change. See 42 C.F.R. § 438.10.

The right to be protected from liability for payment of any fees that are the obligation of the HIDE SNP.

The right to not be charged any cost sharing except as defined in this contract.

Be provided information on how to contact their Care Coordinator.

Appendix J – Relationship with First Tier, Downstream, and Related Entities

Relationship with First Tier, Downstream, and Related Entities

HIDE SNP must ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on HIDE SNP's behalf related to the operation of the HIDE SNP are in compliance with 42 C.F.R. §§422.504, 423.505, 438.3(k), 438.208 and 438.230(b).

HIDE SNP must specifically ensure:

MDHHS or its designee has the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and

MDHHS's or its designee has the right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:

Enrollee protections that include prohibiting First Tier, Downstream and Related Entities from holding an Enrollee liable for payment of any fees that are the obligation of the HIDE SNP;

Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the HIDE SNP's contractual obligations to CMS and MDHHS;

Language that specifies the delegated activities and reporting requirements.

Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where MDHHS or the HIDE SNP determine that such parties have not performed satisfactorily;

Language that specifies the performance of the parties is monitored by the HIDE SNP on an ongoing basis and the HIDE SNP may impose corrective action as necessary;

Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and

Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations, and MDHHS instructions.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:

The credentials of medical professionals affiliated with the party or parties will be either reviewed by the HIDE SNP; or

The credentialing process will be reviewed and approved by the HIDE SNP and the HIDE SNP must audit the credentialing process on an ongoing basis.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the HIDE SNP retains the right to approve, suspend, or terminate any such arrangement.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities must state that neither the HIDE SNP nor the provider has the right to terminate the contract without cause and must require the provider to provide at least sixty (60) calendar day Notice to the HIDE SNP and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the HIDE SNP or Enrollee.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities must state that the HIDE SNP must provide a written statement to a provider of the reason or reasons for termination with cause.

HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

Language that the HIDE SNP is obligated to pay contracted medical providers under the terms of the contract between the HIDE SNP and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the HIDE SNP and the relevant medical provider;

Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

Language that medical providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and Enrollment information;

Language that medical providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;

Language that medical providers maintain the Enrollee Medical Record and information in an accurate and timely manner;

Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and

Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

Language that clearly state the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

Language that prohibits the HIDE SNP from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

Communicated with or advocated on behalf of one or more of their prospective, current or former patients regarding the provisions, terms or requirements of the HIDE SNP's health benefit plans as they relate to the needs of such provider's patients; or

Communicated with one or more of their prospective, current or former patients with respect to the method by which such provider is compensated by the HIDE SNP for services provided to the patient.

Language that states the provider is not required to indemnify the HIDE SNP for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any Claim or action brought against the HIDE SNP based on the HIDE SNP's management decisions, utilization review provisions or other policies, guidelines or actions.

Language that states the HIDE SNP must require providers to comply with the HIDE SNP's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

Language that states the HIDE SNP must notify providers in writing of modifications in payments, modifications in Covered Services or modifications in the HIDE SNP's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The Notice must be provided thirty (30) calendar days before the effective date of such modification unless such other date for

Notice is mutually agreed upon between the HIDE SNP and the provider or unless such change is mandated by CMS or MDHHS without thirty (30) calendar days prior Notice.

Language that states that providers will not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.

Language that states that No payment will be made by the HIDE SNP to a provider for a Provider Preventable Condition; and

As a condition of payment, the provider must comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the HIDE SNP. The provider must comply with such reporting requirements to the extent the provider directly furnishes services.

Language that requires PCPs and specialty provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable.

HIDE SNP must ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

The provider must not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

The HIDE SNP must not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

Nothing in this section will be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation Payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph 2.l. below.

The HIDE SNP must ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers includes language that prohibits the HIDE SNP from imposing a financial risk on medical providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care provider such contract includes specific provisions with respect to the following:

Stop-loss protection;

Minimum patient population size for the Physician or Physician group; and

Identification of the health care services for which the Physician or Physician group is at risk.

The HIDE SNP must ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

Nothing in this section must be construed to restrict or limit the rights of the HIDE SNP to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

Appendix K - MDHHS Financial Monitoring Standards

Reporting Period	Monitoring Indicator	Threshold	MDHHS Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	MDHHS written notification.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Net Worth	Negative Net Worth	MDHHS written notification. Freeze auto assigned enrollees.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial	Medical Loss Ratio	85%	Below 85%: Remit difference to MDHHS	If the Contractor fails to meet the Medical Loss Ratio threshold, the Contractor: 1. Will remit back to MDHHS a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 85% multiplied by the revenue paid to the Contractor during the contract year.
Annual Financial	Dental Claims Loss Ratio	80%	Below 80%: Remit difference to MDHHS	If the Contractor fails to meet the Dental Claims Loss Ratio threshold, the Contractor: 1. Will remit back to MDHHS a rebate in the amount equal to the difference between the calculated dental claims loss ratio and the target loss ratio of 80% multiplied by the revenue paid to the Contractor during the contract year.
Annual Financial Statement	Risk Based Capital (RBC)	150-200% RBC	MDHHS written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.

Annual Financial Statement	RBC	100-149% RBC	MDHHS written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 Days of MDHHS notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	RBC	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

Appendix L - Liquidated Damages

Liquidated Damages		
#	**Finding**	**Damages Assessed**
1	**Failure to Comply with Encounter Data Submission Requirements:** Contractor failure to comply with encounter data submission requirements as described in this Contract. (Section 18.2.)	**$25,000** per occurrence.
2	**Failure to Comply with Encounter Data Correction Requirements:** Contractor failure to comply with timely encounter data correction requirements as described in this Contract. (Section 18.2.)	**$5,000** per day, per occurrence.
3	**Failure to Address MDHHS-OIG Identified Encounter Issues:** Contractor failure to address or resolve, in a timely manner, errors with individual encounter records identified by MDHHS-OIG review of Contractor's quarterly reports submitted pursuant to Section 19.2.	**$500** per day, per identified encounter
4	**Failure to Submit Compliance Review Materials:** Contractor failure to submit all reports required by this Contract for Contract Compliance Review by the due date specified by MDHHS. (Section 15.1.)	**$1,000** per day per occurrence
5	**Late Submission of Information to MDHHS-OIG:** Contractor failure to submit a deliverable for MDHHS-OIG provider referral or member referral request by the due date. (Section 19.2)	**$500** per day per occurrence
6	**Late Submission of Initial CAP:** Contractor failure to submit, by the specified due date, a CAP as prescribed by MDHHS. (Section 15.7.)	**$1,000** per calendar day for each day CAP is late
7	**Failure to Provide Acceptable Initial Corrective Action Plan (CAP):** Contractor failure to provide a complete and acceptable CAP as prescribed by MDHHS by the specified due date. (Section 15.7.)	**$5,000 per occurrence**
8	**Non-Compliance with Accepted CAP:** Contractor failure to comply with an accepted CAP as required by MDHHS. (Section 15.7.)	**$2,500** per calendar day for each day the Contractor fails to comply
9	**Non-Compliance with Key Contract Requirements:** Contractor failure to comply with the Contract requirements, including but not limited to: a. Marketing practices b. Member services c. Provision of Medically Necessary, Covered Services d. Enrollment practices, including but not limited to	The determination of the amount of any monetary sanction must be at the sole discretion of MDHHS, within ranges set by MDHHS. Self-reporting by Contractor will be taken into consideration in determining the amount of the monetary sanction.

	discrimination on the basis of health status or need for health services. e. Provider Networks f. Provider payments g. Financial requirements including but not limited to failure to comply with Physician Incentive Plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program. h. Enrollee satisfaction i. Healthy Behavior policy and operational process j. Performance standards included in Appendix 4 to the Contract. k. Misrepresentation or false information provided to MDHHS, CMS, Providers, Enrollees, or Potential Enrollees l. URAC or NCQA accreditation m. Certificate of Authority n. Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations. o. Care coordination. (Section XX.B.7.)	
1	**Federal Intermediate Sanctions:** Contractor failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with physician incentive plan requirements; or Marketing violations. (Section XX.B.7)	A maximum of **$25,000** for each determination of failure
2	**Federal Intermediate Sanctions:** Determination of Contractor discrimination, or Contractor misrepresentation or false statements to CMS or the State. (Section XX.B.7.)	A maximum of **$100,000** for each determination
3	**Federal Intermediate Sanctions:** Contractor failure to enroll recipients because of a discriminatory practice (subject to the $100,000 overall limit above). (Section 15.2.)	A maximum of **$15,000** for each recipient
4	**Federal Intermediate Sanctions:** Contractor charge of copayments in excess of the amounts permitted under the Medicaid program. Note: MDHHS will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s). (Section 15.2.)	A maximum of **$25,000** or double the amount of the excess charges, whichever is greater

Appendix M – Medicaid Covered Services

This table is current as of the date of the Contract. Contractor should routinely check https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits **for updates to mandatory benefitsw.**

1	Ambulance and other emergency medical transportation
2	Breast pumps; personal use, double--electric
3	Behavioral health services consistent with Appendix E
4	Certified nurse midwife services
5	Certified family nurse practitioner services
6	Chiropractic services
7	Community Health Workers
8	Dental services for adults aged 21 and older
9	Diagnostic laboratory, x-ray, and other imaging services
10	Doula services
11	Durable medical equipment (DME) and supplies including those that may be supplied by a pharmacy
12	Emergency services
13	End Stage Renal Disease (ESRD) services
14	Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
15	Health education
16	Hearing and speech services
17	Hearing aids
18	Home and Community-Based Services
19	Home Health services
20	Hospice services (if requested by the Enrollee)
21	Immunizations
22	Inpatient and outpatient hospital services
23	Intermittent or short-term restorative or rehabilitative services, in a nursing facility
24	Long-term care acute hospital services (LTACH)
25	Maternal and Infant Health Program (MIHP) services
26	Medically Necessary weight reduction services
27	Michigan Diabetes Prevention Program (MiDPP)
28	Non-emergency medical transportation (NEMT) to medically necessary Covered Services and Medicaid services covered outside of this Contract
29	Nursing Facility

30	Nursing Facility Care: Custodial Care Nursing Facility Care: Skilled Nursing & Rehabilitation services (The Medicare requirement for a three-day hospital stay prior to admission to a nursing Facility is not required)
31	Nursing Facility Mental Health Monitoring
32	Out-of-state services authorized by Contractor
33	Parenting and birthing classes
34	Personal Care Services
35	Pharmacy services
36	Podiatry services
37	Practitioners' services
38	Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS.
39	Prosthetics and orthotics
40	Restorative or rehabilitative nursing services
41	Service Animal Stipend
42	Sexually transmitted infections (STI) treatment
43	Tobacco cessation treatment including pharmaceutical and behavioral support.
44	Therapies (speech, language, physical, occupational, family, individual, group, and therapies to support activities of daily living) excluding therapies billed through PIHPs, including therapy provided to persons with intellectual and/or development disabilities (I/DD) or provided by Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
45	Transplant services
46	Vision services
47.	1915c Waiver Home and Community-Based Services • Adaptive Medical Equipment and Supplies • Adult Day Program • Assistive Technology • Chore Services • Environmental Modifications • Expanded Community Living Supports • Fiscal Intermediary • Home Delivered Meals

	• Individual Directed Goods and Services • Non-Medical Transportation • Personal Emergency Response System • Preventive Nursing Services • Private Duty Nursing • Respite • Vehicle Modifications

Appendix N - Non-Emergency Medical Transportation

A. General

a. Contractor must provide non-emergency medical transportation (NEMT) to and from medically necessary Medicare services, Medicaid Covered Services, and Medicaid services covered outside of this Contract in accordance with Medicaid policy.

b. NEMT includes transportation services as well as reimbursement for travel expenses incurred by or on behalf of the Enrollee.

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

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

e. Contractor must develop and maintain a network of qualified NEMT providers.

f. Contractor must ensure that its network has a sufficient number of vehicles and drivers available to provide safe, appropriate, and reliable transportation services to meet the requirements set forth in this Contract.

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

i. Ongoing services, such as dialysis, chemotherapy, substance use disorder (SUD) services provided in the office setting, physical therapy, speech therapy and occupational therapy.

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

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

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

i. Vehicles used by providers meet the safety needs of the Enrollee, including but not limited to seatbelts and child safety seat

requirements, if applicable, and functional heating and air conditioning

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

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

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

v. Vehicles must always be visible by the driver.

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

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

k. The telephone number may be the same as the telephone number described in Section 10.2 Enrollee Service Telephone Responsiveness but must have a dedicated line for NEMT requests.

l. The telephone number must be included on the Enrollee HIDE SNP ID card.

m. Contractor must submit to MDHHS at least annually its policies and procedures for the coverage of NEMT, including reimbursement of Enrollee travel expenses. Contractor must submit equivalent policies and procedures for transportation Subcontractors. Contractor must provide its policies and procedures and related documentation for monitoring Subcontractors to ensure compliance with all provisions of this Contract, including but not limited to passenger safety, timely access to services, Enrollee Complaint resolution, mileage reimbursement, and vehicle inspections.

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

o. Notifying Enrollees of NEMT benefit, including reimbursement of travel expenses to individuals when it is appropriate for the Enrollee to drive

themselves or be driven by a family member, caretaker, friend, neighbor or other individual with a vested interest.

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

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

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

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

t. Contractor/subcontractor must ensure the Enrollee or the Enrollee's representative is asked whether there are any special transport needs at the time of scheduling.

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

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

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

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

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

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

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

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

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

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

viii. Contingency plans for unexpected circumstances. Contractor/subcontractor or NEMT providers must:

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

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

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

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

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

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

B. NEMT complaint resolution and escalation processes.

a. Contractor may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles; prior authorization may not be denied based on distance alone. Contractor must make appropriate accommodations for Enrollees with special transportation needs, including but not limited to Enrollees in CSHCS. MDHHS will monitor transportation services provided by Contractor. To facilitate oversight, Contractor must collect and maintain documentation of all NEMT services provided, which includes but it not limited to the following information for each trip:

i. Enrollee ID

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

iii. Destination

iv. Scheduled pick-up and drop-off times

v. Actual pick-up and drop-off times

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

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

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

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

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

g. Categorized documentation of NEMT-related grievances and appeals. Contractor must monitor and document complaints about NEMT services, including but not limited to those relating to drivers failing to arrive on time or at all for a requested trip and failure to provide transportation that accommodates Enrollee's needs. Contractor must document follow-up, including but not limited to whether rescheduling was necessary and any corrective action with the driver or Subcontractor was appropriate.

h. Documentation log of NEMT-related grievances and appeals must include: complaint reason, complainant name, NEMT service date, transportation provider name, driver name and driver's license number, complaint resolution, and resolution date. This log is only provided to MDHHS upon request.

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

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

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

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

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

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

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

vi. Individual drivers who have any of the following convictions in the past two years will be excluded as an NEMT provider: more than two moving violations, Operating While Intoxicated (OWI), or Driving Under the Influence (DUI)

vii. Exceptions to the traffic violation exclusion:

1. A family member or foster parent with any of the traffic convictions listed may receive reimbursement for NEMT provided to a member who is unable to consent because of an intellectual or developmental disability or a legal guardianship, with the written consent of their legally responsible party.

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

C. NEMT Provision Applicability:

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

b. These requirements are not applicable to the Enrollee.

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

d. These requirements are applicable to taxicab drivers.

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

Appendix O – Contract Compliance Review – Program Integrity

Report Reference	Due Date	Period Covered
Annual Submissions		
Annual Program Integrity Report for Michigan Medicaid	April 15	Previous Fiscal Year Current Fiscal Year Next Fiscal Year
Compliance Program	June 15	Contractor policies and procedures in place and/or revised in: Previous Fiscal Year Current Fiscal Year
Quarterly Submissions		
Quarterly Report	May 15 August 15 November 15 February 15	January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31
Monthly Submissions		
Monthly Overpayment Report	Last day of each month (or next business day)	Preceding Month (e.g. November submission will cover October, January will cover December, etc.
On Request, Or While On Site		
Records	Within three (3) Business Days from the date of the request unless otherwise specified by MDHHS OIG.	
Ad Hoc		
Fraud Referral Form	Within five (5) 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.	