MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

MANAGED CARE REQUIREMENTS

Home and Community Based Services Waiver
For the Elderly and Younger Adults with Disabilities

October 1, 2024

TABLE OF CONTENTS

I. Definitions

The following definitions apply to this contract.

Applicant means a Medicaid beneficiary, or a person who is eligible to be a Medicaid beneficiary who makes an inquiry about voluntarily enrolling in the MI Choice program or is in the process of voluntarily enrolling in the MI Choice program, but is not currently an enrollee or participant of a specific PAHP. The Michigan Department of Health and Human Services (MDHHS) also uses the term potential enrollee to describe an applicant.

Capitation Payment means a payment MDHHS makes periodically to the PAHP on behalf of each participant enrolled under this contract for the provision of MI Choice services. MDHHS makes the payment regardless of whether the particular participant receives services during the period covered by the payment.

Cold Call Marketing means any unsolicited personal contact by the PAHP with a potential participant for marketing as defined in §438.104(a).

Comprehensive Risk Contract means a risk contract between MDHHS and the PAHP that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services (the MI Choice contract is NOT a Comprehensive Risk Contract:

- Outpatient hospital services.
- Rural health clinic services.
- FQHC services.
- Other laboratory and X-ray services.
- Nursing facility (NF) services.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- Family planning services.
- Physician services.
- Home health services.

Enrollee means a Medicaid beneficiary currently enrolled in the PAHP in the MI Choice program. MDHHS also uses the term participant to describe an enrollee.

Excluded Services means services that are not included in the capitation payment provided to the PAHP and may be furnished outside of the MI Choice program. Only the MI Choice services and supports coordination responsibilities described in MI Choice policy Are included in the capitation payment to the PAHP.

Federally Qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health Care Professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse

(including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Insurance means an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. Medicaid is a form of health insurance and is considered payer of last resort.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries—

- Through payments to, or arrangements with, providers;
- Under a comprehensive risk contract with the State; and
- Meets the following criteria—
  a. First became operational prior to January 1, 1986; or
  b. Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990) and section 205 of the Medicare Improvements for Patients and Providers Act of 2008.

Indian Health Care Provider (IHCP) means a health care provider that specifically serves Native Americans. For the purposes of this contract, IHCP incorporates all Indian Health Services, Tribal Health Centers, and Urban Indian Organizations.

Long-Term Services and Supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Program means a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

Marketing means any communication, from a PAHP to an individual who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the individual to enroll in that particular PAHP's Medicaid product, or either to not enroll in, or to disenroll from, another PAHP's Medicaid product.

Marketing Materials means materials produced in any medium, by or on behalf of a PAHP that can reasonably be interpreted as intended to market to individuals.

Medically Necessary means health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Network Provider means any provider, group of providers, or entity that has a network provider agreement with a PAHP, or a subcontractor, and receives Medicaid funding

directly or indirectly to order, refer, or render covered services as a result of the contract between MDHHS and the PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Non-Participating Provider means a provider, group of providers, or entity that has not enrolled with the Medicare or Medicaid programs. This may also be a provider that is not a network provider and does not have a provider agreement with the PAHP or furnish services covered by the contract between MDHHS and the PAHP.

Non-Risk Contract means a contract under which the PAHP—

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR §447.362; and
- May be reimbursed by the State at the end of the contract period based on the incurred costs, subject to the specified limits.

Participant means a Medicaid recipient beneficiary currently enrolled in a PAHP in the MI Choice Waiver Program.

Participating Provider means a provider, group of providers, or entity that agrees to enroll with the Medicare or Medicaid programs. This may also be a network provider.

Plan means the array of medical and health-related services covered by a specific health insurance program or benefit. Plan may also refer to the managed care entity that administers a Medicaid program, service, or benefit.

Potential Enrollee means a Medicaid beneficiary, or a person who is eligible to be a Medicaid beneficiary who makes an inquiry about voluntarily enrolling in the MI Choice Program, or is in the process of voluntarily enrolling in the MI Choice program, but is not currently an enrollee or participant of a specific PAHP. MDHHS also uses the term applicant to describe a potential enrollee.

Preauthorization means approval that is granted for a specific Medicaid-covered benefit or service before the benefit or service is rendered to the Medicaid beneficiary. This is also referred to as prior authorization. MI Choice services must be authorized on the participant's person-centered plan of services before being furnished.

Prepaid Ambulatory Health Plan (PAHP) means an entity that:

- Provides MI Choice services to enrollees under contract with MDHHS, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

For purposes of this document, the PAHP is also the Grantee, or the waiver agency.

Prevalent Non-English Language is one that is spoken as the primary language by more than 5% of the PAHP's enrollees.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries**.**

Primary Care Case Manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

- A physician assistant.
- A nurse practitioner.
- A certified nurse-midwife.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the service.

Risk Contract means a contract between the State and the PAHP under which the PAHP

- Assumes risk for the cost of the services covered under the contract; and
- Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

State plan approved rates means amounts calculated for specific services identifiable as having been provided to an individual beneficiary described under CMS approved rate methodologies in the Medicaid State plan. Supplemental payments contained in a State plan are not, and do not constitute, State plan approved rates.

Subcontractor means an individual or entity that has a contract with the PAHP that relates directly or indirectly to the performance of the PAHP's obligations under its contract with MDHHS. A network provider is not a subcontractor by virtue of the network provider agreement with the PAHP.

II. Contract Requirements (42 CFR §438.3)

A. Payment (42 CFR §438.3(c)). The following requirements apply to the final capitation rate and the receipt of capitation payments under the contract:

1. The final capitation rate for the PAHP must be:

   a. Specifically identified in the applicable contract submitted for CMS review and approval. This information is contained in Attachment Q of this contract.

   b. The final capitation rates must be based only upon service covered under the State

plan and additional services deemed by MDHHS to be necessary to comply with the requirements of 42 CFR 438 Subpart K (applying parity standards from the Mental Health Parity and Addiction Equity Act) and represent a payment amount that is adequate to allow the PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

2. Capitation payments may only be made by MDHHS and retained by the PAHP for Medicaid-eligible enrollees.

B. Enrollment Discrimination Prohibited (42 CFR §438.3(d))

1. The PAHP accepts individuals eligible for enrollment in the order in which they apply, according to the waiting list priority categories, up to the limits set under the contract in Attachment Q.

2. The PAHP will not, based on health status, or need for health care services, discriminate against individuals eligible to enroll.

3. The PAHP will not discriminate against individuals eligible to enroll based on race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

C. Coverage of Additional Services (42 CFR §438.3(e))
The PAHP may cover, for enrollees, services in addition to those covered under the MI Choice contract as long as the PAHP voluntarily agrees to provide them, although the cost of these services cannot be included when determining the capitation payments for the MI Choice program. (This Federal requirement replaces services previously known as Gap-filling and Temporarily Ineligible Participant (TIP) services in previous contracts.)

D. Choice of Providers (42 CFR §438.3(l))
The PAHP must allow each enrollee to choose his or her network provider to the extent possible and appropriate.

E. Record Inspection, Retention, and Audits (42 CFR §438.3(h), (u), and (m))

1. The PAHP must allow the State, CMS, the Office of Inspector General, the Comptroller General, and their designees to, at any time, inspect and audit the records, or documents, premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of the audit period, whichever is later.

2. The PAHP and its network providers must retain for a period of no less than ten years the following information, as applicable:

   i. Enrollee grievance and appeal records in 42 CFR §438.416
   ii. Base data in 42 CFR §438.5(c)

iii. Medical Loss Ratio reports in 42 CFR §438.8(k), and
iv. The data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610.

3. The PAHP must submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

III. Special Contract Provisions Related to Payment (42 CFR §438.6(c)(iii)(A))

A. Delivery system and provider payment initiatives

1. MDHHS requires the PAHP to adopt a minimum fee schedule for network providers that offer Community Living Supports that is equal to or greater than the state-plan approved rates for Home Help services. This fee schedule is found in the Adult Services Manual 138 (https://dhhs.michigan.gov/OLMWEB/EX/AS/Public/ASM/138.pdf#pagemode=bookmarks) MDHHS has already included the $2.35 per hour direct care wage increase plus the extra $0.28 per hour for employer related expenses within the Home Help rates.

2. MDHHS requires the PAHP to adopt a minimum fee schedule for network providers that offer Private Duty Nursing services that is equal to or greater than the state-plan approved rates for Private Duty Nursing. This fee schedule is found on the MDHHS website: Doing Business with MDHHS>>Health Care Providers>>Click on Health Care Providers again>> Providers>>Billing and Reimbursement>>Information Specific to Different Providers>>Private Duty Nurse, or through this link Information Specific to Different Providers (michigan.gov).

IV. Medical Loss Ratio (MLR) Reporting Requirements (42 CFR §438.8)

The PAHP must calculate and report a MLR in accordance with this section.

A. Definitions. As used in this section, the following terms have the indicated meanings:

1. *Credibility adjustment* means an adjustment to the MLR for a partially credible PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation.

2. *Full credibility* means a standard for which the experience of a PAHP is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. A PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR.

3. *Member months* mean the number of months an enrollee or a group of enrollees is covered by the PAHP over a specified period, such as a year.

4. *MLR reporting year* means a period of 12 months consistent with the rating period selected by the State.

5. *No credibility* means a standard for which the experience of a PAHP is determined to be insufficient for the calculation of a MLR. A PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements.

6. *Non-claims costs* means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e.ii) of this section); expenditures on activities that improve health care quality (as defined in paragraph (e.iii) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f.ii) of this section).

7. *Partial credibility* means a standard for which the experience of a PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

B. The State mandates a minimum MLR for each PAHP. The minimum MLR is equal to or higher than 85 percent and is calculated and reported for each MLR reporting year by the PAHP, consistent with this section.

C. The MLR experienced for each PAHP in an MLR reporting year is the ratio of the numerator (as defined in paragraph D of this section) to the denominator (as defined in paragraph E of this section). A MLR may be increased by a credibility adjustment, in accordance with paragraph G of this section.

D. Numerator

1. The numerator of a PAHP's MLR for a MLR reporting year is the sum of the PAHP's incurred claims (as defined in paragraph 2 of this section); the PAHP's expenditures for activities that improve health care quality (as defined in paragraph 3 of this section); and fraud prevention activities (as defined in paragraph 4 of this section).

2. Incurred claims

a. Incurred claims must include the following:

i. Direct claims that the PAHP paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of §438.3(e) provided to enrollees.

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported

iii. Withholds from payments made to network providers.

iv. Claims that are recoverable for anticipated coordination of benefits.

v. Claims payments recoveries received as a result of subrogation.

vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

vii. Changes in other claims-related reserves.

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b. Amounts that must be deducted from incurred claims include overpayment recoveries received from network providers and prescription drug rebates received and accrued.

c. Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to network providers.

ii. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph 4 of this section.

d. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

e. Amounts that must be excluded from incurred claims:

i. Non-claims costs, as defined in paragraph ii of this section, which include the following:

1) Amounts paid to third party vendors for secondary network savings.

2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in §438.3(e) and provided to an enrollee.

4) Fines and penalties assessed by regulatory authorities.

ii. Amounts paid to the State as remittance under paragraph I of this section.

iii. Amounts paid to network providers under to §438.6(d).

f. Incurred claims paid by one PAHP that is later assumed by another entity must be reported by the assuming PAHP for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding PAHP.

3. Activities that improve health care quality must be in one of the following categories:

a. A PAHP activity that meets the requirements of 45 CFR §158.150(b) (Activities that improve health care quality) and is not excluded under 45 CFR §158.150(c).

b. A PAHP activity related to any EQR-related activity as described in 42 CFR §438.358(b) and (c).

c. Any PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR §158.151, and is not considered incurred claims, as defined in paragraph D.2 of this section.

4. Fraud prevention activities. PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph D.2.c.ii this section.

E. Denominator

1. Required elements. The denominator of a PAHP's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the PAHP's premium revenue (as defined in paragraph E.2 of this section) minus the PAHP's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph E.3 of this section) and is aggregated in accordance with paragraph H of this section.

2. Premium revenue includes the following for the MLR reporting year:

a. State capitation payments, developed in accordance with 42 CFR §438.4, PAHP for all enrollees under a risk contract approved under 42 CFR §438.3(a), excluding payments made under 42 CFR §438.6(d).

b. State-developed one-time payments, for specific life events of enrollees.

c. Other payments to the PAHP approved under 42 CFR §438.6(b)(3).

d. Unpaid cost-sharing amounts that the PAHP could have collected from enrollees under the contract, except those amounts the PAHP can show it made a reasonable, but unsuccessful, effort to collect.

e. All changes to unearned premium reserves.

f. Net payments or receipts related to risk sharing mechanisms developed in accordance with §438.5 or §438.6.

3. Federal, State, and local taxes, licensing and regulatory fees for the MLR reporting year include:

a. Statutory assessments to defray the operating expenses of any State or Federal department.

b. Examination fees in lieu of premium taxes as specified by State law.

c. Federal taxes and assessments allocated to PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

d. State and local taxes and assessments including:

i. Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

iv. State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

v. State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

e. Payments made by a PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR §158.162(c), limited to the highest of either:

i. Three percent of earned premium; or

ii. The highest premium tax rate in the State for which the report is being submitted, multiplied by the PAHP's earned premium in the State.

4. The total amount of the denominator for a PAHP which is later assumed by another entity must be reported by the assuming PAHP for the entire MLR reporting year and no amount under this paragraph for that year may be reported by the ceding PAHP.

F. Allocation of expense

1. General requirements

a. Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

2. Methods used to allocate expenses

a. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

b. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

c. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

G. Credibility adjustment

1. A PAHP may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, as described in paragraph J of this section.

2. A PAHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

3. If a PAHP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section.

4. On an annual basis, CMS will publish base credibility factors for PAHPs that are developed according to the following methodology:

a. CMS will use the most recently available and complete managed care encounter data or FFS claims data, and enrollment data, reported by the states to CMS. This data may cover more than 1 year of experience.

b. CMS will calculate the credibility adjustment so that a PAHP receiving a capitation payment that is estimated to have a medical loss ratio of 85 percent would be expected to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time.

c. The minimum number of member months necessary for a PAHP's medical loss ratio to be determined at least partially credible will be set so that the credibility adjustment would not exceed 10 percent for any partially credible PAHP. Any PAHP with enrollment less than this number of member months will be determined non-credible.

d. The minimum number of member months necessary for a PAHP's medical loss ratio to be determined fully credible will be set so that the minimum credibility adjustment for any partially credible PAHP would be greater than 1 percent. Any PAHP with enrollment greater than this number of member months will be determined to be fully credible.

e. A PAHP with a number of enrollee member months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of enrollee member months.

f. CMS may adjust the number of enrollee member months necessary for a PAHP's experience to be non-credible, partially credible, or fully credible so that the

standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to 1,000 or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives of this regulation.

H. PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

I. As required by the State, a PAHP must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher as set by the State as described in paragraph B of this section.

J. Reporting requirements

1. MDHHS requires each PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:

   a. Total incurred claims.

   b. Expenditures on quality improving activities.

   c. Expenditures related to activities compliant with 42 CFR §438.608(a)(1) through (5), (7), (8) and (b).

   d. Non-claims costs.

   e. Premium revenue.

   f. Taxes, licensing and regulatory fees.

   g. Methodology(ies) for allocation of expenditures.

   h. Any credibility adjustment applied.

   i. The calculated MLR.

   j. Any remittance owed to the State, if applicable.

   k. A comparison of the information reported in this paragraph with the audited financial report required under 42 CFR §438.3(m).

   l. A description of the aggregation method used under paragraph I of this section.

   m. The number of member months.

2. A PAHP must submit the report required in paragraph J.1 of this section within 12 months of the end of the MLR reporting year.

3. PAHPs must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PAHP,

whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

K. MDHHS, in its discretion, may exclude a PAHP that is newly contracted with the State from the requirements in this section for the first year of the PAHP's operation. Such PAHPs will be required to comply with the requirements in this section during the next MLR reporting year in which the PAHP is in business with the State, even if the first year was not a full 12 months.

L. In any instance when MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the State, the PAHP must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in paragraph K of this section.

M. PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph J of this section.

V. Information Requirements (42 CFR §438.10)

A. Definitions. As used in this section, the following terms have the indicated meanings:

1. *Limited English proficient (LEP)* means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

2. *Prevalent* means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are LEP.

3. *Readily accessible* means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

B. Basic Rules:
1. PAHPs must provide the required information in this section to each enrollee.

2. Enrollee information required in this section may not be provided electronically by the State, or PAHP unless all of the following are met:

a. The format is readily accessible;

b. The information is placed in a location on the State or PAHP's web site that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed;

d. The information is consistent with the content and language requirements of this

section; and

e. The enrollee is informed that the information is available in paper form without charge upon request and the PAHP provides it upon request within 5 business days.

3. Each PAHP must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.

C. Language and Format

1. Each PAHP must make oral interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided. Large print means printed in a font size no smaller than 18 point.

2. Each PAHP must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the PAHP's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

3. Each PAHP must make interpretation services available to each potential enrollee and make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

4. Each PAHP must notify potential enrollees and enrollees:

   a. That oral interpretation is available for any language and written translation is available in prevalent languages;

   b. That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and

   c. How to access the services in paragraphs D.4.a and D.4.b of this section.

5. Each PAHP must provide all written materials for potential enrollees and enrollees consistent with the following:

   a. Use easily understood language and format.

b. Use a font size no smaller than 12 point.

c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

d. Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

D. Information for potential enrollees

1. The PAHP must provide the information specified in paragraph E.2 of this section to each potential enrollee, either in paper or electronic form as follows:

   a. At the time the potential enrollee first becomes eligible to enroll in the MI Choice program; and

   b. Within a timeframe that enables the potential enrollee to use the information in choosing among available PAHPs.

2. The information for potential enrollees must include, at a minimum, all of the following:

   a. Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR §438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;

   b. The basic features of managed care;

   c. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee must also be specified;

   d. The service area covered by each PAHP;

   e. Covered benefits including:

      i. Which benefits are provided by the PAHP; and

      ii. Which, if any, benefits are provided directly by the State.

      iii. For a counseling or referral service that the PAHP does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service;

   f. The provider directory information required in paragraph G of this section;

   g. The requirements for each PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68;

h. The PAHP's responsibilities for coordination of enrollee care; and

i. To the extent available, quality and performance indicators for each PAHP, including enrollee satisfaction.

E. Information for all enrollees of PAHPs

1. The PAHP must make a good faith effort to give written notice of termination of a contracted provider, within 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

2. The State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR §438.56 at least annually. Such notification must clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the enrollee based on their specific circumstance.

F. Enrollee handbook or Participant handbook

1. Each PAHP must provide each enrollee an enrollee handbook within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR §147.200(a). MDHHS developed the MI Choice Waiver Participant Handbook as the enrollee handbook for this program. Each PAHP must use the MI Choice Waiver Participant Handbook available online to meet this requirement:

   http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42549_42592-151693--,00.html

2. The content of the enrollee handbook must include information that enables the enrollee to understand how to use the managed care program effectively. This information must include at a minimum:

   a. Benefits provided by the PAHP.

   b. How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.

      i. In the case of a counseling or referral service that the PAHP does not cover because of moral or religious objections, the PAHP must inform enrollees that the service is not covered by the PAHP.

      ii. The PAHP must inform enrollees how they can obtain information from the State about how to access the services described in paragraph (h)(ii)(2)(a) of this section.

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

d. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

e. The extent to which, and how, after-hours and emergency coverage are provided, including:

   i. What constitutes an emergency medical condition and emergency services

   ii. The fact that prior authorization is not required for emergency services.

   iii. The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.

f. Any restrictions on the enrollee's freedom of choice among network providers.

g. The extent to which, and how, enrollees may obtain benefits from out-of-network providers.

h. Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100.

i. Grievance, appeal, and fair hearing procedures and timeframes, consistent with 42 CFR §438.400 through §438.424, in a State-developed or State-approved description. Such information must include:

   i. The right to file grievances and appeals.

   ii. The requirements and timeframes for filing a grievance or appeal.

   iii. The availability of assistance in the filing process.

   iv. The right to request a State fair hearing after PAHP has made a determination on an enrollee's appeal that is adverse to the enrollee.

   v. The fact that, when requested by the enrollee, benefits that the PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

j. How to exercise an advance directive, as set forth in 42 CFR §438.3(j). For PAHPs, information must be provided only to the extent that the PAHP includes any of the providers described in 42 CFR §489.102(a). The information must reflect changes in State law as soon as possible, but not later than 90 days after the effective date of the change.

k. How to access auxiliary aids and services, including additional information in alternative formats or languages.

l. The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees.

m. Information on how to report suspected fraud or abuse;

n. Any other content required by the State.

3. Information required by this paragraph to be provided by a PAHP will be considered to be provided if the PAHP:

a. Mails a printed copy of the information to the enrollee's mailing address;

b. Provides the information by email after obtaining the enrollee's agreement to receive the information by email;

c. Posts the information on the Web site of the PAHP and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

d. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

4. The PAHP must give each enrollee notice of any change that the State defines as significant in the information specified in this paragraph F, at least 30 days before the intended effective date of the change.

G. Provider Directory

1. Each PAHP must make available in paper form upon request and electronic form, the following information about its network providers:

a. The provider's name as well as any group affiliation.

b. Street address(es).

c. Telephone number(s).

d. Web site URL, as appropriate.

e. Specialty, as appropriate.

f. Whether the provider will accept new enrollees.

g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

h. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

2. The provider directory must include the information in paragraph G.1 of this section for

each of the following provider types covered under the contract:

a. Physicians, including specialists;

b. Hospitals;

c. Pharmacies;

d. Behavioral health providers; and

e. LTSS providers, as appropriate.

3. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PAHP receives updated provider information. This includes making updates to mobile-enabled electronic directories.

4. Provider directories must be made available on the PAHP's Web site in a machine-readable file and format as specified by the Secretary.

VI. Serving Native Americans and Working with Indian Health Care Providers (42 CFR §438.14)

A. If an IHCP is a network provider with the PAHP, Native Americans who enroll in MI Choice must be allowed to choose the IHCP as their primary care physician, as long as that provider has capacity to furnish services. (42 CFR §438.14(b)(3))

B. IHCPs that are enrolled in Medicaid as Federally Qualified Health Centers (FQHC) but are not participating providers of the PAHP must be paid an amount equal to the amount the PAHP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the PAHP pays and what the IHCP FQHC would have received under fee for service reimbursement. (42 CFR §438.14(c)(1))

C. When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the PAHP, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Services (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under fee for service payment methodology. (42 CFR §438.14(c)(2))

D. The PAHP must demonstrate that it has sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Native American enrollees who are eligible to receive services. (42 CFR §438.14(b)(1), 42 CFR §438.14(b)(5))

E. Regardless of IHCPs participation in the PAHP’s provider network, IHCPs must be paid for covered services provided to Native American enrollees who are eligible to receive services as follows (42 CFR §438.14(b)(2)(i)-(iii)):

1. At a negotiated rate between the PAHP and IHCP or,
2. In the absence of a negotiated rate, at a rate not less than the level and amount of payment the PAHP would make for the services to a participating provider that is not an IHCP; and
3. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

F. Native American enrollees are permitted to obtain covered services from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services. (42 CFR §438.14(b)(4))

G. The PAHP must permit an out-of-network IHCP to refer a Native American enrollee to a network provider. (42 CFR §438.14(b)(6))

VII. Disenrollment: Requirements and Limitations (42 CFR §438.56)

A. Disenrollment requested by the PAHP

1. The PAHP may request disenrollment of a participant for reasons specified in MI Choice policy.

2. The PAHP may not request disenrollment because of:
   a. an adverse change in the enrollee's health status,
   b. the enrollee's utilization of medical services,
   c. the enrollee's diminished mental capacity, or
   d. the enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PAHP seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

3. The PAHP will document reasons for requesting disenrollment within the case record as specified in MI Choice policy. MDHHS will periodically evaluate disenrollment reasons to assure all requested disenrollments are for reasons allowed by contract.

B. Disenrollment requested by the enrollee

1. An enrollee may request disenrollment as follows:

   a. For cause, at any time.

   b. Without cause, at the following times:

      i. During the 90 days following the date of the beneficiary's initial enrollment into the PAHP or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later.

      ii. At least once every 12 months thereafter.

      iii. Upon automatic reenrollment when a beneficiary was automatically reenrolled

after a disenrollment based solely because the enrollee lost their Medicaid eligibility for a period of two months or less, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

iv. When the State imposes the intermediate sanction specified in this document.

C. Procedures for disenrollment

1. The enrollee (or his or her representative) must submit an oral or written request, to the PAHP to process disenrollment requests.

2. The following are cause for disenrollment:

   a. The enrollee moves out of PAHP's service area.

   b. Because of moral or religious objections, the PAHP does not cover the service the enrollee seeks.

   c. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

   d. For enrollees that use MLTSS, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the PAHP and, as a result, would experience a disruption in their residence or employment.

   e. Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs.

3. PAHP action on request.

   a. The PAHP may either approve a request for disenrollment by or on behalf of an enrollee or the PAHP must refer the request to the State.

   b. If the PAHP fails to make a disenrollment determination so that the enrollee can be disenrolled within the timeframes specified in paragraph D.1 of this section, the disenrollment is considered approved.

4. State agency action on request.

   a. For a request received directly from the enrollee, or one referred by the PAHP, the State agency must take action to approve or disapprove the request based on the following:

      i. Reasons cited in the request.

ii. Information provided by the PAHP at the agency's request.

iii. Any of the reasons specified in paragraph C.2 of this section.

5. Use of the PAHP's grievance procedures.

a. MDHHS requires that the enrollee seek redress through the PAHP's grievance system before MDHHS will make a determination on the enrollee's request.

b. The PAHP's grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in paragraph D.1 of this section.

c. If, as a result of the grievance process, the PAHP approves the disenrollment, MDHHS is not required to make a determination in accordance with paragraph C.4 of this section.

D. Timeframe for disenrollment determinations

1. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the PAHP refers the request to the State.

2. If the PAHP or MDHHS (whichever is responsible) fails to make the determination within the timeframes specified in paragraph D.1 of this section, the disenrollment is considered approved for the effective date that would have been established had MDHHS or the PAHP complied with paragraph D.1 of this section.

E. Automatic reenrollment: The PAHP may reenroll a beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, provided the beneficiary continues to meet MI Choice Program eligibility criteria.

VIII. Enrollee Rights (42 CFR §438.100)

A. The PAHP must have and MDHHS must ensure:

1. The PAHP has written policies regarding the enrollee rights specified in this section; and

2. The PAHP complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.

B. Specific rights

1. Basic requirement. MDHHS must ensure that each enrollee is guaranteed the rights as specified in paragraphs B.2 and B.3 of this section.

2. An enrollee of the PAHP has the following rights: The right to:

a. Receive information in accordance with 42 CFR §438.10.

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

c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR §438.10(g)(2)(ii)(A) and (B).)

d. Participate in decisions regarding his or her health care, including the right to refuse treatment.

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

3. An enrollee of the PAHP the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

C. Free exercise of rights. The PAHP must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the State, PAHP, or network providers treat the enrollee.

D. Compliance with other Federal and State laws. The PAHP must comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.)

IX. Provider Enrollee Communications (42 CFR §438.102)

A. Anti-gag Clause (42 CFR §438.102(a))

1. A PAHP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a participant who is his or her patient.

2. For the participant’s health status, medical care, or treatment options, including an alternative treatment that may be self-administered.

3. For any information the participant needs in order to decide among all relevant treatment options.

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

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

B. Moral or Religious Objections (42 CFR §438.102(b))

1. The PAHP may object to a service on moral or religious grounds. When the PAHP would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service but objects based on moral or religious grounds, the PAHP must furnish information about the services it does not cover as follows:

   a. To the State

      i. With its application for a Medicaid contract.

      ii. Whenever it adopts the policy during the term of the contract.

   b. Consistent with the provisions of 42 CFR §438.10, to enrollees, within 90 days after adopting the policy for any particular service.

2. The PAHP must furnish the information at least 30 days before the effective date of the policy.

3. As specified in §438.10(g)(2)(ii)(A) and (B), the PAHP must inform enrollees how they can obtain information from the State about how to access the service excluded under this section.

C. A PAHP that violates the prohibition of paragraph A.1 of this section is subject to intermediate sanctions as defined in this document.

X. Marketing Activities State Approval (42 CFR §438.104)

A. The PAHP must not distribute any marketing materials without first obtaining MDHHS approval. Before approving any marketing material, the PAHP will adequately assure MDHHS the content of the material is accurate and does not mislead, confuse, or defraud applicants, participants, or MDHHS.

B. Marketing materials will be closely monitored during Administrative Quality Assurance Reviews, and at any other time MDHHS staff deems appropriate.

C. The PAHP must comply with the information requirements of 42 CFR §438.10 to ensure that before enrollment the participant receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll. Marketing materials cannot contain any assertion or statement (whether written or oral) that:

1. The participant must enroll in the PAHP in order to obtain benefits or in order not to lose benefits.

2. That the PAHP is endorsed by CMS, the Federal or State government or similar entity.

3. Marketing requirements must include the following:

   a. That the entity distributes the materials to its entire service area as indicated in the contract.

   b. That the entity does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

   c. That the entity does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

XI. Liability for Payment (42 CFR §438.106)

A. Each PAHP must provide that its Medicaid enrollees are not held liable for any of the following:

1. The PAHP's debts, in the event of the entity's insolvency.

2. Covered services provided to the enrollee, for which:

   a. The State does not pay the PAHP; or

   b. The State or PAHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

3. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the PAHP covered the services directly.

XII. Member Advisory Committee (42 CFR §438.110)

The PAHP must establish and maintain a member advisory committee that is comprised of a reasonably representative sample of the PAHP’s enrollees or other individuals representing those enrollees.

XIII. PAHP Standards For Provider Networks and Service Delivery (42 CFR §438.206 through §438.242)

A. Provider Network (42 CFR §438.206)

1. The PAHP must maintain a network of appropriate providers that is:

   a. Supported by written agreements

   b. Sufficient to provide adequate access to all services covered under the contract

2. In establishing and maintaining the provider network, the PAHP must consider each of

the following:

a. The anticipated participant enrollments

b. The expected utilization of services, taking into consideration the characteristics and health care needs of the specific participants served

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services

d. The number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

e. The network providers must provide physical access, reasonable accommodation, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

3. Each PAHP uses an open bid process to contract with qualified providers in their service area that are willing to furnish MI Choice services. MDHHS requires each PAHP to have a provider network with capacity to serve at least 125% of their monthly slot utilization for each MI Choice service, and at least two providers for each MI Choice service. This assures network capacity as well as choice of providers. When providers cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDHHS.

4. If the PAHP is unable to provide necessary medical services covered under the contract to a particular participant the PAHP must adequately and timely cover these services out of network for the participant, for as long as the PAHP is unable to provide them within the network. Since there is no cost to the participant for the PAHP's in-network services, there may be no cost to the participant for medically-necessary services provided out-of-network.

5. The PAHP shall ensure timely access to MI Choice services for each participant as specified in MI Choice policy, and require the same of its network providers.

6. The PAHP and its providers must offer hours of operation that are no less than the hours of operation available to non-Medicaid eligible individuals and other individuals not enrolled in the MI Choice program, but served by either the PAHP or the provider.

7. MI Choice services must be available 24 hours per day, 7 days per week when medically necessary. This requirement shall not be construed as a requirement to provide MI Choice services 24 hours per day, 7 days per week.

8. The PAHP must:

a. Establish mechanisms to ensure network providers comply with the timely access

requirements specified in paragraphs 1 through 7 of this section.

b. Monitor contracted providers regularly to determine compliance.

c. Take corrective action if there is a failure to comply with these requirements.

B. Coordination and Continuity of Care (42 CFR §438.208)

1. Each PAHP must implement procedures to deliver care to and coordinate services for all enrollees. These procedures must meet requirements defined in MI Choice policy and must do the following:

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

   b. Coordinate the services the PAHP furnishes to the enrollee:

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

      ii. With the services the enrollee receives from any other MCO, PIHP, or PAHP;

      iii. With the services the enrollee receives in FFS Medicaid; and

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

   c. Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;

   d. Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

   e. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

2. Each PAHP must implement mechanisms to comprehensively assess each enrollee to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring as specified in MI Choice policy.

3. The PAHP must assist each participant with developing a person-centered service plan (PCSP) as defined in MI Choice policy. The PCSP must be:

   a. Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee:

b. Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1) and (2);

c. Approved by the PAHP in a timely manner;

d. In accordance with any applicable State quality assurance and utilization review standards; and

e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per 42 CFR §441.301(c)(3).

4. Per 42 CFR §438.62, PAHPs must comply with the transition of care policy provided by MDHHS to allow for a continuity of care period for situations in which a participant transitions from one PAHP to another. The PAHP must follow the MDHHS policy at a minimum, but may add to it to meet unique needs of the PAHP and the participant. This continuity of care must include the following:

   a. The participant has access to the same services that were received prior to the transition to the new PAHP. The participant must also be permitted to retain the same providers for a period of time if the providers are not in the network of the new PAHP.

   b. The participant is referred to appropriate in-network service providers to meet the participant's needs.

   c. The PAHP previously serving the participant must comply with requests for historical utilization data and medical records, as appropriate, from the new PAHP in accordance with Federal and State law.

C. Coverage and Authorization of Services (42 CFR §438.210)

1. PAHPs are required to authorize and furnish MI Choice services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under Medicaid Fee for Service programs and options.

2. The PAHP:

   a. Must ensure the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

   b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the participant.

   c. May place appropriate limits on a service on the basis of medical necessity or for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose, and are authorized in a manner that reflects the participant's ongoing need for such services and supports.

d. And its subcontractors have in place, and follow, written policies and procedures for the authorization of services.

e. Must have mechanisms to ensure consistent application of review criteria for authorization decisions.

f. Must consult with the requesting provider for medical services when appropriate.

g. Must authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

h. Must use individuals with appropriate expertise in addressing the participant's medical, behavioral health or LTSS needs to make decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

3. Notice of adverse benefit determination.

a. The PAHP must notify the requesting provider, and give the enrollee written notice of any decision by the PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

b. The participant's notice must meet the requirements of 42 CFR §438.404.

4. Each PAHP must adhere to the following timeframes for decisions and notices:

a. For standard authorization decisions, provide notice as expeditiously as the participant's condition requires, not to exceed 10 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

i. The enrollee, or the provider, requests extension; or

ii. The PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

b. Expedited authorization decisions

i. The PAHP shall make an expedited authorization decision when the standard authorization timeframe could seriously jeopardize the participant's life, health, or ability to attain, maintain, or regain maximum function as indicted by a provider or the PAHP.

ii. The PAHP must make an expedited authorization decision as expeditiously as the participant's health condition requires, and no later than 72 hours after the receipt of the request for services.

iii. The PAHP may extend the 72 hour period by up to 14 calendar days if the participant requests an extension, or if the PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the

participant's interest.

5. Neither MDHHS nor the PAHP may structure compensation to individuals or entities that conduct utilization management activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

D. Practice Guidelines (42 CFR §438.236)

1. Each PAHP shall adopt practice guidelines that meet the following requirements:

   a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

   b. Consider the needs of the enrollees.

   c. Are adopted in consultation with contracting health care professionals.

   d. Are reviewed and updated periodically as appropriate.

2. Each PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

3. The PAHP shall ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

E. Health information systems (42 CFR §438.242)

1. General rule. The PAHP must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this section. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

2. The PAHP must comply with the basic elements of a health information system as follows:

   a. Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act.

   b. Collect data on enrollee and provider characteristics as specified by MDHHS, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by MDHHS.

   c. Ensure that data received from providers is accurate and complete by:

      i. Verifying the accuracy and timeliness of reported data, including data from network providers the PAHP is compensating on the basis of capitation

payments.

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

iii. 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. Make all collected data available to MDHHS and upon request to CMS.

e. Implement an Application Programming Interface (API) as specified below in accordance with 42 CFR §431.60 as if such requirements applied directly to the PAHP.

i. Technical Requirements. A PAHP implementing an API (42 CFR §431.60):

1) Must implement, maintain, and use API technology conformant with 45 CFR 170.215;

2) Must conduct routine testing and monitoring, and update as appropriate, to ensure the API functions properly, including assessments to verify that the API is fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in 45 CFR parts 160 and 164, 42 CFR parts 2 and 3, and other applicable law protecting the privacy and security of individually identifiable data;

3) Must comply with the content and vocabulary standards requirements included below, as applicable to the data type or data element, unless alternate standards are required by other applicable law:

a) Content and vocabulary standards at 45 CFR 170.213 where such standards are applicable to the data type or element, as appropriate; and

b) Content and vocabulary standards at 45 CFR part 162 and § 423.160 of this chapter where required by law, or where such standards are applicable to the data type or element, as appropriate.

4) May use an updated version of any standard or all standards required under paragraph 3) of this section, where:

a) Use of the updated version of the standard is required by other applicable law, or

b) Use of the updated version of the standard is not prohibited under other applicable law, provided that:

1. For content and vocabulary standards other than those at 45 CFR 170.213, the Secretary has not prohibited use of the updated version of a standard for purposes of this section or 45 CFR part 170;

2. For standards at 45 CFR 170.213 and 45 CFR 170.215, the National Coordinator has approved the updated version for use in the ONC Health IT Certification Program; and

3. Use of the updated version of a standard does not disrupt an end user's ability to access data through the API.

ii. Documentation requirements for APIs. For each API implemented in accordance with this section, the PAHP must make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the information listed in this paragraph. For the purposes of this section, “publicly accessible” means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;

1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

2) The software components and configurations an application must use in order to successfully interact with the API and process its response(s); and

3) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

f. Implement, by January 1, 2021, and maintain a publicly accessible standards-based API specified below in accordance with § 431.70, which must include all information specified in section V.G.1 and V.G.2 above and consistent with 42 CFR §438.10(h)(1) and (2).

i. Access to published provider directory information (42 CFR § 431.70).

1) The PAHP must implement and maintain a publicly accessible, standards-based Application Programming Interface (API) that is conformant with the technical requirements noted in section XIII.E.2.e.i and is accessible via a public-facing digital endpoint on the PAHP's website.

2) The API must provide a complete and accurate directory of the PAHP's provider directory information specified in section 1902(a)(83) of the Social Security Act, updated no later than 30 calendar days after the PAHP receives provider directory information or updates to provider directory information.

a) All providers within the PAHP's provider network who are contracted to furnish MI Choice services must be listed in the provider directory.
b) If the PAHP develops a provider directory that also includes providers who do not furnish MI Choice services, the PAHP must clearly delineate those providers who furnish MI Choice services within the directory.

3) This section is applicable beginning January 1, 2021.

3. Enrollee encounter data. The PAHP must:

a. Collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

b. Submit enrollee encounter data to MDHHS at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.

c. Submit all enrollee encounter data to MDHHS in the form and manner described under 42 CFR §438.818 and MDHHS guidance including but not limited to MDHHS:

i. Companion Guides/Data Clarification Documents
ii. Electronic File Layout Instructions
iii. Encounter Reporting Presentations

d. Ensure that all submitted encounter data is timely, accurate and complete.

e. Submit all subcontractor encounter data. Subcontracted encounter data must comply with all MDHHS requirements and specifications.

f. Submit encounter data to MDHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

g. 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. The PAHP must review the CHAMPS Encounter Transaction Results Report and reconcile the errors listed in the report.

h. Make all necessary adjustment 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. The PAHP must notify MDHHS when the adjustments are resubmitted.

4. Failure of the PAHP to submit encounter data and resubmissions in accordance with MDHHS timeliness standard may result in contract remedies including but not limited to liquidated damages, sanctions, and penalties in accordance with contract standards.

5. PAHP encounter submissions must be certified by an authorized agent of the PAHP in

accordance with 42 CFR 438.606.

6. MDHHS must review and validate that the encounter data collected, maintained, and submitted to the State by the PAHP meets the requirements of this section. MDHHS will deem encounter data submitted when it is accepted, certified, and processed in MDHHS systems. MDHHS will follow procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph 3 of this section is a complete and accurate representation of the services provided to the enrollees under this contract.

7. MDHHS may consider approval of extended timeframes for encounter data submission and resubmission on a case by case basis per the PAHP's written request which must include an extenuating reason for such a request and estimated date of completion.
   a. Written requests for an extension must be received by MDHHS no less than two business days, prior to the due date outlined in the MDHHS encounter submission timeliness standard. Any extension requests not received by the extension request due date stated in this paragraph will be denied.
   b. Excessive extension requests will be considered PAHP non-compliant performance and MDHHS may pursue contract remedies including but not limited to liquidated damages, sanctions and penalties in accordance with contract standards.

8. Encounter Data Quality Standards:
   a. MDHHS will review for and validate all submitted encounter data for completeness and accuracy.
   b. The PAHP must fully cooperate with all MDHHS efforts to monitor the PAHP's compliance with the requirements of encounter submission. The PAHP must comply with all requests related to encounter data monitoring in a timely manner as directed by MDHHS.
   c. The PAHP must submit encounter data for MI Choice participants' services that the PAHP incurred a financial liability and must include encounters for services provided that were eligible to be processed by where no financial liability was incurred by the PAHP.
   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 and
      iv. Average paid amount per service, by billing code
   e. PAHP must collect and maintain all encounter data for each covered service and supplemental benefit services provided to participants, including encounter data from any sub-capitated sources.
   f. PAHP must evaluate the completeness and quality of its subcontractor encounter data and keep record of its procedures and evaluations and report results with the Quality Management Plan.
   g. PAHP must participate in site visits and other reviews and assessments conducted by MDHHS or its designee, for the purpose of evaluating the PAHP's collection, submission, and maintenance of encounter data.
   h. PAHP must cooperate and comply with any audit arranged for by MDHHS to

determine accuracy, truthfulness, and completeness of submitted encounter data.

i. PAHP must participate in MDHHS' Encounter Quality Initiative (EQI). The PAHP must:
   i. Attend and participate in all MDHHS scheduled monthly quality phone meetings
   ii. Submit timely EQI reports and reconciliation template in accordance with the Encounter Quality Initiative Schedule
   iii. Submit a completed EQI reconciliation template in accordance with the Encounter Quality Initiative Schedule

j. PAHP failure to participate in MDHHS encounter quality reviews in accordance with MDHHS standards may entitle MDHHS to pursue contract remedies including but not limited to sanctions, penalties, and/or liquidated damages.

F. The PAHP is required to submit documentation as specified by the State, but no less frequently than the following:
   1. At the time it enters into a contract with the State;
   2. On an annual basis;
   3. At any time there has been a significant change (as defined by the State) in the PAHP's operations that would affect adequacy of capacity and services, including changes in PAHP services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the PAHP.

XIV. Quality Assessment and Performance Improvement Program (42 CFR §438.330)

A. Definitions

1. *Access*, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by the PAHP successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).

2. *External quality review (EQR)* means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a PAHP or their contractors furnish to Medicaid beneficiaries.

3. *External quality review organization (EQRO)* means an organization that meets the competence and independence requirements set forth in §438.354, and performs EQR, other EQR-related activities as set forth in 42 CFR §438.358, or both.

4. *Financial relationship means—*

   a. A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

   b. A compensation arrangement with an entity.

5. *Health care services* means all Medicaid services provided by a PAHP under contract with the State Medicaid agency in any setting, including but not limited to medical care,

behavioral health care, and long-term services and supports.

6. *Outcomes* mean changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

7. *Quality,* as it pertains to EQR, means the degree to which a PAHP increases the likelihood of desired outcomes of its enrollees through:

   a. Its structural and operational characteristics.

   b. The provision of services consistent with current professional, evidenced-based-knowledge.

   c. Interventions for performance improvement.

8. *Validation* means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

B. General rules

1. Each PAHP must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in paragraph C of this section.

2. The PAHP must modify its quality improvement plan if CMS specifies performance measures and performance improvement projects (PIPs) to include in the standard measures identified and PIPs required by the State in accordance with paragraphs D and E of this section.

C. Basic elements of quality assessment and performance improvement programs. The comprehensive quality assessment and performance improvement program described in paragraph B of this section must include at least the following elements:

1. Performance improvement projects in accordance with paragraph E of this section.

2. Collection and submission of performance measurement data in accordance with paragraph D of this section.

3. Mechanisms to detect both underutilization and overutilization of services.

4. Mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan; and

5. Participate in efforts to prevent, detect, and remediate critical incidents (consistent with assuring enrollee health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per 42 CFR §441.302(h).

D. The PAHP must include in its quality management plan, the standard performance measures identified by CMS and MDHHS.

1. These performance measures will include measures relating to qualify of life, rebalancing, and community integration activities for MI Choice participants.

2. Annually, the PAHP will measure and report to MDHHS its performance using the standard measures required by CMS and MDHHS.

E. Performance improvement projects

1. Each PAHP will conduct performance improvement projects, including those required by CMS in accordance with paragraph B.2 of this section, that focus on both clinical and nonclinical areas.

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

a. Measurement of performance using objective quality indicators.

b. Implementation of interventions to achieve improvement in the access to and quality of care.

c. Evaluation of the effectiveness of the interventions based on the performance measures in paragraph E.2.a of this section.

d. Planning and initiation of activities for increasing or sustaining improvement.

3. MDHHS requires each PAHP to report the status and results of each project conducted per paragraph E.1 of this section annually.

F. The PAHP must undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under the contract.

XV. State Review of the Accreditation Status of the PAHP (42 CFR §438.332)

A. Each PAHP shall inform MDHHS whether it has been accredited by a private independent accrediting entity.

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

1. Accreditation status, survey type, and level (as applicable);

2. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3. Expiration date of the accreditation.

XVI. Grievance and Appeal System (42 CFR §438.400 through §438.424)

A. Statutory basis. This subpart is based on the following statutory sections:

1. Section 1902(a)(3) of the Social Security Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

2. Section 1902(a)(4) of the Social Security Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

3. Section 1932(b)(4) of the Social Security Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

B. Definitions. As used in this subpart, the following terms have the indicated meanings:

1. *Adverse benefit determination* means any of the following:

a. 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.

b. The reduction, suspension, or termination of a previously authorized service.

c. The denial, in whole or in part, of payment for a service.

d. The failure to provide services in a timely manner.

e. The failure of the PAHP to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

f. For a resident of an area with only one PAHP, the denial of an enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

g. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

2. *Appeal* means a review by a PAHP of an adverse benefit determination.

3. *Grievance* means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the PAHP to make an authorization decision.

4. *Grievance and appeal system* means the processes the PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

5. *State fair hearing* means the process set forth in subpart E of part 431 of 42 CFR.

C. General Requirements (42 CFR §438.402)

1. Each PAHP must have a grievance and appeal system in place for enrollees.

2. Each PAHP may have only one level of appeal for enrollees.

3. Filing requirements

a. Authority to file

i. An enrollee may file a grievance and request an appeal with the PAHP. An enrollee may request a State fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.

1) Deemed exhaustion of appeals processes. In the case of a PAHP that fails to adhere to the notice and timing requirements in 42 CFR §438.408, the enrollee is deemed to have exhausted the PAHP's appeals process. The enrollee may initiate a State fair hearing.

2) External medical review. The State may offer and arrange for an external medical review if the following conditions are met.

a) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

b) The review must be independent of both the State and PAHP.

c) The review must be offered without any cost to the enrollee.

d) The review must not extend any of the timeframes specified in 42 CFR §438.408 and must not disrupt the continuation of benefits in 42 CFR §438.420.

ii. With the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout this section, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in 42 CFR §438.420(b)(5).

b. Timing

i. Grievance. An enrollee may file a grievance with the PAHP **at any time**.

ii. Appeal. Following receipt of a notification of an adverse benefit determination by the PAHP, an enrollee has **60 calendar days** from the date on the adverse benefit determination notice to file a request for an appeal to the PAHP.

c. Procedures

i. Grievance. The enrollee may file a grievance either orally or in writing with the PAHP.

ii. Appeal. The enrollee may request an appeal either orally or in writing.

D. Timely and Adequate Notice of Adverse Benefit Determination (42 CFR §438.404)

1. The PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 CFR §438.10.

2. The notice must explain the following:

a. The adverse benefit determination the PAHP 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 appeal of the adverse benefit determination, including information on exhausting the PAHP's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c).

d. The procedures for exercising the rights specified in this section.

e. The circumstances under which an appeal process can be expedited and how to request it.

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

3. The PAHP must mail the notice within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the following timeframes:

i. **Advance notice.** The PAHP must send a notice at least 10 days before the date of action, except as permitted under 3.a.ii and 3.a.iii.

ii. **Exceptions from advance notice.** The PAHP may send a notice not later than the date of action if

1) The agency has factual information confirming the death of an enrollee;

2) The agency receives a clear written statement signed by an enrollee that:

   a) He or she no longer wishes services; or

   b) Gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;

   c) The enrollee has been admitted to an institution where he is ineligible under the plan for further services;

   d) The enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

   e) The agency establishes the fact that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

   f) A change in the level of medical care is prescribed by the enrollee's physician;

   g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

   h) The date of action will occur in less than 10 days.

3) **Notice in cases of probable fraud.** The agency may shorten the period of advance notice to 5 days before the date of action if:

   a) The agency has facts indicating that action should be taken because of probable fraud by the enrollee; and

   b) The facts have been verified, if possible, through secondary sources.

b. For denial of payment, at the time of any action affecting the claim.

c. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR §438.210(d)(1).

d. If the PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii), it must:

   i. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

   ii. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

e. For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

f. For expedited service authorization decisions, within the timeframes specified in 42 CFR §438.210(d)(2).

E. Handling of Grievances and Appeals (42 CFR §438.406)

1. In handling grievances and appeals, each PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. A PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

   a. Acknowledge receipt of each grievance and appeal.

   b. Ensure that the individuals who make decisions on grievances and appeals are individuals:

      i. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

      ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

         1) An appeal of a denial that is based on lack of medical necessity.

         2) A grievance regarding denial of expedited resolution of an appeal.

         3) A grievance or appeal that involves clinical issues.

      iii. Who 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.

   c. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)

   d. Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.

   e. Provide the enrollee and his or her representative the enrollee's case file, including

medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP (or at the direction of the PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).

f. Include, as parties to the appeal

i. The enrollee and his or her representative; or

ii. The legal representative of a deceased enrollee's estate.

F. Resolution and Notification (42 CFR §438.408)

1. Each PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes specified in this section.

2. Specific timeframes

a. For standard resolution of a grievance and notice to the affected parties, the timeframe may not exceed 90 calendar days from the day the PAHP receives the grievance.

b. For standard resolution of an appeal and notice to the affected parties no longer than 30 calendar days from the day the PAHP receives the appeal. This timeframe may be extended under paragraph 3 of this section.

c. Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, no longer than 72 hours after the PAHP receives the appeal. This timeframe may be extended under paragraph 3 of this section.

3. The PAHP may extend the timeframes from paragraph 2 of this section by up to 14 calendar days if

a. The enrollee requests the extension; or

b. The PAHP shows (to the satisfaction of MDHHS, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

c. Requirements following extension. If the PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.

ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the enrollee's health condition requires

and no later than the date the extension expires.

d. Deemed exhaustion of appeals processes. In the case of a PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the PAHP's appeals process. The enrollee may initiate a State fair hearing.

4. Format of notice

a. The PAHP will use the state-established method to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.10. The PAHP must use notice templates developed by the State.

b. Appeals.

i. For all appeals, the PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.

ii. For notice of an expedited resolution, the PAHP must also make reasonable efforts to provide oral notice.

5. The written notice of the resolution must include the following:

a. The results of the resolution process and the date it was completed.

b. For appeals not resolved wholly in favor of the enrollees

i. The right to request a State fair hearing and how to do so.

ii. The right to request and receive benefits while the hearing is pending, and how to make the request.

iii. That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the PAHP's adverse benefit determination.

6. Requirements for State fair hearings

a. An enrollee may request a State fair hearing only after receiving notice that the PAHP is upholding the adverse benefit determination.

i. In the case of a PAHP that fails to adhere to the notice and timing requirements in 42 CFR §438.408, the enrollee is deemed to have exhausted the PAHP's appeals process. The enrollee may initiate a State fair hearing.

ii. The State may offer and arrange for an external medical review if the following conditions are met.

1) The review must be at the enrollee's option and must not be required before

or used as a deterrent to proceeding to the State fair hearing.

2) The review must be independent of both the State and PAHP.

3) The review must be offered without any cost to the enrollee.

4) The review must not extend any of the timeframes specified in 42 CFR §438.408 and must not disrupt the continuation of benefits in 42 CFR §438.420.

iii. The enrollee must request a State fair hearing no later than 120 calendar days from the date of the PAHP's notice of resolution.

b. The parties to the State fair hearing include the PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

G. Expedited Resolution of Appeals (42 CFR §438.410)

1. Each PAHP must establish and maintain an expedited review process for appeals, when the PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

2. The PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

3. Action following denial of a request for expedited resolution. If the PAHP denies a request for expedited resolution of an appeal, it must

a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).

b. Follow the requirements in 42 CFR §438.408(c)(2).

H. Information to Providers and Subcontractors (42 CFR §438.414)

The PAHP must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

I. Recordkeeping Requirements (42 CFR §416)

1. The PAHP must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

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

a. A general description of the reason for the 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 appeal or grievance, if applicable.

e. Date of resolution at each level, if applicable.

f. Name of the covered person for whom the appeal or grievance was filed.

3. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

J. Continuation of Benefits (42 CFR §438.420)

1. Definition. As used in this section *Timely files* means files for continuation of benefits on or before the later of the following:

a. Within 10 calendar days of the PAHP sending the notice of adverse benefit determination.

b. The intended effective date of the PAHP's proposed adverse benefit determination.

2. The PAHP must continue the enrollee's benefits if all of the following occur:

a. The enrollee files the request for an appeal timely in accordance with 42 CFR §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

e. The enrollee timely files for continuation of benefits.

3. If, at the enrollee's request, the PAHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of 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 calendar days after the PAHP sends the notice of an adverse resolution to the enrollee's appeal under 42 CFR §438.408(d)(2).

c. A State fair hearing office issues a hearing decision adverse to the enrollee.

4. If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the PAHP's adverse benefit determination, the PAHP may recover the cost of

services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

K. Effectuation of Reversed Appeal Resolutions (42 CFR §438.424)

1. Services not furnished while the appeal is pending. If the PAHP or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PAHP 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.

2. Services furnished while the appeal is pending. If the PAHP or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PAHP must pay for those services.

XVII. Program Integrity Requirements (42 CFR §438.600 through §438.610)

A. Data, information, and documentation that must be submitted (42 CFR §438.604)

1. MDHHS requires the PAHP to submit to the State the following data:

a. Encounter data in the form and manner described in 42 CFR §438.818.

b. Data on the basis of which MDHHS certifies the actuarial soundness of capitation rates to the PAHP under 42 CFR §438.4, including base data described in 42 CFR §438.5(c) that is generated by the PAHP.

c. Data on the basis of which the MDHHS determines the compliance of the PAHP with the medical loss ratio requirement described in 42 CFR §438.8.

d. Data on the basis of which MDHHS determines that the PAHP has made adequate provision against the risk of insolvency as required under 42 CFR §438.116.

e. Documentation described in 42 CFR §438.207(b) on which MDHHS bases its certification that the PAHP has complied with MDHHS requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.

f. Information on ownership and control described in 42 CFR §455.104 from the PAHP and its subcontractors as governed by 42 CFR §438.230.

g. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

2. In addition to the data, documentation, or information specified in paragraph A of this section, the PAHP must submit any other data, documentation, or information relating to the performance of the PAHP's obligations under this part required by MDHHS or CMS.

B. Source, Content, and Timing of Certification (42 CFR §438.606)

1. Source of certification. For the data, documentation, or information specified in 42 CFR §438.604, MDHHS requires the data, documentation or information the PAHP submits to MDHHS be certified by either the PAHP'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.

2. Content of certification. The certification provided by the individual in paragraph A of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.

3. Timing of certification. MDHHS requires the PAHP to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).

C. Program Integrity Requirements (42 CFR §438.608)

1. Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The PAHP must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

   a. A compliance program that includes, at a minimum, all of the following elements:

      i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

      ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.

      iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

      iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.

      v. Effective lines of communication between the compliance officer and the organization's employees.

      vi. Enforcement of standards through well-publicized disciplinary guidelines.

      vii. Establishment and implementation 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 the requirements under the contract.

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

c. Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:

   i. Changes in the enrollee's residence;

   ii. The death of an enrollee.

d. Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PAHP.

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.

f. In the case of PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, 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.

g. Provision for the prompt referral of any potential fraud, waste, or abuse that the PAHP identifies to the MDHHS Office of Inspector General.

h. Provision for the PAHP'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.

2. Disclosures. Each PAHP and any subcontractors must:

a. Provide written disclosure of any prohibited affiliation under 42 CFR §438.610.

b. Provide written disclosures of information on ownership and control required under 42 CFR §455.104.

c. Report to the State within 60 calendar days when it has identified the capitation

payments or other payments in excess of amounts specified in the contract.

3. Treatment of recoveries made by the PAHP or its subcontractors of overpayments to providers.

   a. When the PAHP or its subcontractors recovers payments to providers:

      i. The PAHP may retain the recovered overpayment including those based upon fraud, waste or abuse.

      ii. The PAHP or its subcontractors must adjust encounter data related to the recovered funds appropriately within CHAMPS within 30 days of receiving the recovered funds.

      iii. The PAHP must report to MDHHS all capitation payments affected by the recovered funds within 30 days of receiving the recovered funds.

      iv. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

   b. Each PAHP and its subcontractors must have mechanism for a network provider to report to the PAHP when it has received an overpayment, to return the overpayment to the PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the PAHP in writing of the reason for the overpayment.

   c. Each PAHP must report annually to the State on their recoveries of overpayments, including the recoveries of overpayments made by subcontractors.

D. Prohibited Affiliations (42 CFR §438.610)

1. A PAHP may not knowingly have a relationship of the type described in paragraph D.3 of this section with the following:

   a. An individual or 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 Executive Order No. 12549.

   b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101, of a person described in paragraph 1.a of this section.

2. A PAHP may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

3. The relationships described in paragraph 1 of this section, are as follows:

   a. A director, officer, or partner of the PAHP.

b. A subcontractor of the PAHP, as governed by 42 CFR §438.230.

c. A person with beneficial ownership of 5 percent or more of the PAHP's equity.

d. A network provider or person with an employment, consulting or other arrangement with the PAHP entity for the provision of items and services that are significant and material to the PAHP's obligations under this contract.

4. If a State finds that a PAHP is not in compliance with paragraphs 1 and 2 of this section, the State:

a. Must notify the Secretary of the noncompliance.

b. May continue an existing agreement with the PAHP unless the Secretary directs otherwise.

c. May not renew or otherwise extend the duration of an existing agreement with the PAHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

d. Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Social Security Act.

5. Consultation with the Inspector General. Any action by the Secretary described in paragraphs 4.b or 4.c of this section is taken in consultation with the Inspector General.

XVIII. Sanctions

A. Basis for imposition of sanctions:

1. MDHHS must impose sanctions when it makes any of the determinations specified in paragraphs 2 through 5 of this section. MDHHS may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

2. MDHHS determines that the PAHP acts or fails to act as follows:

a. Fails substantially to provide medically necessary services that the PAHP is required to provide, under law or under its contract with MDHHS, to an enrollee covered under the contract.

b. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

c. Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical

services.

d. Misrepresents or falsifies information that it furnishes to CMS or to the State.

e. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

3. MDHHS determines that the PAHP has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

4. MDHHS determines the PAHP has violated any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations. For any such violation, only the sanctions specified in B.1.c through B.1.e may be imposed.

5. MDHHS determines, based on findings from onsite surveys, enrollee or other complaints, financial status, program data, or any other source, that the waiver agency did any of the following:

   a. Violated the administrative authority granted to the waiver agency, including but not limited to:

      i. Failure to follow established waiting list policies, procedures, or protocols, including failure to properly place applicants on the waiting list or place them in the wrong priority category of the waiting list, and failure to properly and timely follow up on referrals for the MI Choice program.

      ii. Completing or conducting an inappropriate or inaccurate assessment of an applicant or participant.

      iii. Reducing or denying a participant's MI Choice services improperly or inappropriately.

      iv. Failure to follow Federal or State rules, regulations, or policies related to person-centered planning.

      v. Failure to provide proper notification of adverse actions taken by the waiver agency toward a MI Choice applicant or participant. This includes failure to provide proper adverse benefit determinations, advanced action notices, and adequate action notices to the affected applicant or participant.

      vi. Improperly monitoring self-determination arrangements for MI Choice participants.

      vii. Failure to submit accurate and complete reports to MDHHS on or before the report due date.

   b. Failed to follow Nursing Facility Level of Care and Level of Care Determination (LOCD) policies and procedures, including but not limited to:

i. Completing an inaccurate LOCD.

ii. Denying enrollment or terminating an enrollment in MI Choice based upon an inaccurate LOCD.

iii. Failure to respond to requests for a verification review of an LOCD conducted by the waiver agency.

c. Managed the provider network inadequately or inappropriately, including but not limited to:

i. Failure to substantially provide the MI Choice services authorized in the person-centered service plan to a MI Choice participant.

ii. Failure to provide or allow access to adequate training for supports coordinators, waiver agency staff, or contracted providers.

iii. Failure to develop or maintain an adequate provider network.

iv. Enrolling providers that are non-complaint with the Home and Community Based Settings Final Rule.

v. Failure to use an open bid process for contracting with network providers.

d. Disregarded or jeopardized the health and welfare of a MI Choice participant, including but not limited to:

i. Abusing or neglecting a MI Choice participant.

ii. Failing to report or falsely reporting a critical incident for a MI Choice participant.

iii. Imposing an unnecessary delay for the authorization or provision of MI Choice services.

iv. Unnecessarily restricting flexibility or budget authority with MI Choice participants using self-determination.

e. Maintained an ineffective Quality Assurance and Performance Improvement (QAPI) plan including, but not limited to:

i. Receiving the same citation on the Clinical Quality Assurance Review (CQAR) report for three or more consecutive years without demonstrated improvement.

ii. Failing to respond timely or completely to requests from MDHHS or its contractors for information related to the CQAR, Administrative Quality Assurance Review (AQAR), Network Adequacy Validation (NAV), Encounter Data Validation (EDV), External Quality Review (EQR), Medical Loss Ratio (MLR), Managed Care Program Annual Report (MCPAR), or any other report required by CMS or MDHHS to assess the quality of the MI Choice program.

iii. Failing to implement actions specified in an approved corrective action plan.

iv. Failing to demonstrate improvement with performance improvement projects (PIPs)

v. Failure to provide an in-depth analysis of the waiver agency's quality strategy in the annual QAPI report.

B. Types of intermediate sanctions

1. The types of intermediate sanctions that MDHHS may impose include the following:

a. Civil money penalties in the amounts specified in C below.

b. Appointment of temporary management as provided in D.

c. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

d. Suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the PAHP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.

e. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or MDHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

2. MDHHS retains authority to impose additional sanctions under Michigan statutes or Michigan regulations that address areas of noncompliance specified in A, as well as additional areas of noncompliance. Nothing in this subpart prevents Michigan from exercising that authority. Additional sanctions may include any or all the following:

a. The provision of technical assistance to the waiver agency to improve performance.
b. Requiring the waiver agency to implement a corrective action plan that is approved by MDHHS.
c. Increased monitoring or auditing of the waiver agency by MDHHS or its contractor until the issue is resolved.
d. The imposition of monetary sanctions.
e. TTermination of the waiver agency's contract.

C. Amounts of civil money penalties

1. If MDHHS imposes civil monetary penalties as provided under B.1.a, the maximum civil money penalty the State may impose varies depending on the nature of the PAHP's action or failure to act, as provided in this section.

2. Specific limits.

a. The limit is $25,000 for each determination under A.2.a, A.2.e, and A.3.

b. The limit is $100,000 for each determination under A.2.c or A.2.d.

c. The limit is $15,000 for each beneficiary MDHHS determines was not enrolled because of a discriminatory practice under A.2.c. (This is subject to the overall limit of $100,000 under paragraph 2.b of this section).

d. The limit is $15,000 for each affected beneficiary MDHHS determines was affected by actions described under A.5.a.ii, A.5.a.iii, A.5.a.v, A.5.b.i-iii, A.5.c.i, and A.5.d.i-iv. (This is NOT subject to the overall limit of $100,000 under paragraph 2.b of this section).

e. The limit is $50,000 for each determination under A.5.a.i, A.5.a.iv, A.5.a.vi, A.5.a.vii, A.5.c.ii-v, and A.5.e.i-v.

3. Specific amount. For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. Michigan must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

D. Special rules for temporary management

1. Optional imposition of sanction. If MDHHS imposes temporary management under B.1.b, MDHHS may do so only if it finds (through onsite surveys, enrollee or other complaints, financial status, or any other source) any of the following:

   a. There is continued egregious behavior by the PAHP, including but not limited to behavior that is described in A, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act.

   b. There is substantial risk to enrollees' health.

   c. The sanction is necessary to ensure the health of the PAHP’s enrollees:

      i. While improvements are made to remedy violations under A.

      ii. Until there is an orderly termination or reorganization of the PAHP.

2. Required imposition of sanction. MDHHS must impose temporary management (regardless of any other sanction that may be imposed) if it finds that the PAHP has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR §438. MDHHS must also grant enrollees the right to terminate enrollment without cause and must notify the affected enrollees of their right to terminate enrollment.

3. Hearing. MDHHS may not delay imposition of temporary management to provide a hearing before imposing this sanction.

4. Duration of sanction. MDHHS may not terminate temporary management until it determines that the PAHP can ensure that the sanctioned behavior will not recur.

E. Termination of this contract
MDHHS has the authority to terminate the PAHP’s contract and enroll that entity's enrollees in other waiver agencies or provide their Medicaid benefits through other options included

in the State plan, if MDHHS determines that the PAHP has failed to do either of the following:

1. Carry out the substantive terms of its contract.

2. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

F. Notice of sanction and pre-termination hearing

1. Notice of sanction. Except as provided in D.3, before imposing any of the intermediate sanctions specified in B, MDHHS must give the PAHP timely written notice that explains the following:

   a. The basis and nature of the sanction.

   b. Any other appeal rights that the State elects to provide.

2. Pre-termination hearing

   a. General rule. Before terminating the PAHP's contract under E, MDHHS must provide the PAHP a pre-termination hearing.

   b. Procedures. MDHHS must do all the following:

      i. Give the PAHP written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.

      ii. After the hearing, give the entity written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination.

      iii. For an affirming decision, give enrollees of the PAHP notice of the termination and information, consistent with 42 CFR §438.10, on their options for receiving Medicaid services following the effective date of termination.

G. Disenrollment during termination hearing process

After MDHHS notifies the PAHP that it intends to terminate the contract, MDHHS may do the following:

1. Give the PAHP's enrollees written notice of the State's intent to terminate the contract.

2. Allow enrollees to disenroll immediately without cause.

H. Notice to CMS

MDHHS must give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed in A. The notice must be given no later than 30 days after MDHHS imposes or lifts a sanction and specify the PAHP, the kind of sanction, and the reason for

imposing or lifting each sanction.

XIX. Fraud and Abuse Reporting

A. The PAHP must report fraud and abuse information to the State. PAHPs must report the following to the State:

1. Number of complaints of fraud and abuse made to State that warrant preliminary investigation.

2. For each complaint that warrants investigation, supply the:
   a. Name, ID number
   b. Source of complaint
   c. Type of provider
   d. Nature of complaint
   e. Approximate dollars involved, and
   f. Legal and administrative disposition of the case.

XX. Disclosure of Information by the PAHP and Its Subcontractors and Network Providers (42 CFR §455.100 through §455.106)

A. Purpose (42 CFR §455.100)

1. This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth requirements regarding:

   a. Disclosure by providers and fiscal agents of ownership and control information; and

   b. Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

2. The subpart also specifies conditions under which the CMS will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

B. Definitions

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

2. **Disclosing Entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

3. **Other Disclosing Entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Social Security Act. This includes:

   a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance

organization that participates in Medicare (title XVIII);

b. Any Medicare intermediary or carrier; and

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Social Security Act.

4. **Fiscal Agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

5. **Group of Practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

6. **Health Insuring Organization** (HIO) has the meaning specified in 42 CFR §438.2.

7. **Indirect Ownership Interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

8. **Managed Care Entity (MCE)** means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

9. **Managing Employee** means a general manager, business manager, administrator, director, 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.

10. **Ownership Interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

11. **Person With an Ownership or Control Interest** means a person or corporation that:

    a. Has an ownership interest totaling 5 percent or more in a disclosing entity;

    b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

    c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

    d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

    e. Is an officer or director of a disclosing entity that is organized as a corporation; or

    f. Is a partner in a disclosing entity that is organized as a partnership.

12. **Prepaid Ambulatory Health Plan (PAHP)** has the meaning specified in 42 CFR §438.2.

13. **Prepaid Inpatient Health Plan (PIHP)** has the meaning specified in 42 CFR §438.2.

14. **Primary Care Case Manager (PCCM)** has the meaning specified in 42 CFR §438.2.

15. **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

16. **Subcontractor** means:

    a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

    b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

17. **Supplier** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

18. **Termination** means:

    a. For a:

        i. Medicaid provider, a State Medicaid program has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

        ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

    b. In both programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

    c. The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to fraud, integrity, or quality.

19. **Wholly Owned Supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

C. Determination of ownership or control percentages (42 CFR §455.102)

1. Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10

percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2. Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

D. Disclosure by Medicaid providers and fiscal agents: Information on ownership and control (42 CFR §455.104)

1. MDHHS agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities, including PAHPs.

2. MDHHS requires that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

   a. All of the following:

      i. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

      ii. Date of birth and Social Security Number (in the case of an individual).

      iii. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

   b. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

   c. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has

an ownership or control interest.

d. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

3. When the disclosures must be provided—

a. Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

i. Upon the provider or disclosing entity submitting the provider application.

ii. Upon the provider or disclosing entity executing the provider agreement.

iii. Upon request of MDHHS during the re-validation of enrollment process.

iv. Within 35 days after any change in ownership of the disclosing entity.

b. Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

i. Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

ii. Upon the fiscal agent executing the contract with the State.

iii. Upon renewal or extension of the contract.

iv. Within 35 days after any change in ownership of the fiscal agent.

c. Disclosures from managed care entities. Disclosures from managed care entities are due at any of the following times:

i. Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

ii. Upon the managed care entity executing the contract with the State.

iii. Upon renewal or extension of the contract.

iv. Within 35 days after any change in ownership of the managed care entity.

4. All disclosures must be provided to MDHHS.

5. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

E. Information related to business transactions (42 CFR §455.105)

1. MDHHS must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business

transactions in accordance with paragraph 2 of this section.

2. A provider must submit, within 35 days of the date on a request by the Secretary or MDHHS, full and complete information about:

   a. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   b. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

   c. Denial of Federal financial participation (FFP).

      i. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or MDHHS under paragraph 2 of this section or under 42 CFR §420.205 (Medicare requirements for disclosure).

      ii. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or MDHHS and ending on the day before the date on which the information was supplied.

F. Information on persons convicted of crimes (42 CFR §455.106)

1. Before MDHHS enters into or renews a provider agreement, or at any time upon written request by MDHHS, the provider must disclose to MDHHS the identity of any person who:

   a. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

   b. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

2. Notification to Inspector General.

   a. MDHHS must notify the Inspector General of the Department of any disclosures made under paragraph 1 of this section within 20 working days from the date it receives the information.

   b. The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

3. Denial or termination of provider participation.

   a. MDHHS may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent

or managing employee of the provider, 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.

b. MDHHS may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph 1 of this section.

XXI. Third Party Liability Requirements (42 CFR §433.135 through §433.154, 42 CFR §447.20)

A. The PAHP, its subcontractors, and its network providers are required to abide by the Coordination of Benefits Chapter of the Medicaid Provider Manual. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/MDHHS. References in this section to the PAHP also include all PAHP subcontractors and network providers. These provisions must be included in any contracts between the PAHP and it's subcontractors.

B. Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries, including MI Choice enrollees. Medicaid is considered the payer of last resort. When a beneficiary with Medicare or Other Insurance coverage is enrolled in the MI Choice program, the PAHP is responsible for the Medicaid payment liability for the services covered by the MI Choice program.

C. Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of an enrollee's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. The PAHP must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to submitting encounter claims with MDHHS. Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the PAHP is aware that the enrollee had other insurance coverage for the services rendered.

D. Encounter Claim Void Process. MDHHS will send a Pending Claim Void notice via mail and the Archived Documents repository within CHAMPS when it is determined that a provider did not hold another resource liable for payment after Medicaid adjudicated the encounter claim. If the encounter claim was lacking information about the existence of another resource, the PAHP must resubmit the claim in CHAMPS as an adjustment and include the proper Claim Adjustment Reason Code within 30 days of the date provided on the Pending Claim Void notice. MDHHS will automatically void the claim after the 30 days if no adjustment is made in CHAMPS from the PAHP. The PAHP will then have to bill the identified resource for the claim. It is the PAHP's responsibility to remediate with the primary payer prior to rebilling Medicaid for the claim.

E. Information about an enrollee's other insurance is available through the CHAMPS Eligibility Inquiry or vendor that receives eligibility data from the CHAMPS 270/271 transaction.

1. The PAHP must ask the enrollee if other insurance coverage exists at the time of service. If the enrollee identifies other insurance coverage that is not listed in the eligibility response, the provider must use that other insurance and report it to MDHHS by contacting Medicaid Provider Inquiry or the Third Party Liability Section.

2. If the enrollee does not agree with the other insurance information contained in the eligibility response, (e.g., other insurance coverage is no longer available), instruct the enrollee to notify the local MDHHS office of the change.

3. If the PAHP elects to initiate a change to the enrollee eligibility response, complete the Request to Add, Terminate, or Change Other Insurance (form DCH-0078). The form should be submitted prior to submitting encounter data to. If known, the PAHP should include the policy's per diem payment amount in the comments section of the form. The TPL Section will verify the information provided and update the enrollee's CHAMPS eligibility information accordingly.

4. The PAHP should have the rendering provider bill the other resource first. The PAHP should include any payments made by the other resource on encounter data submitted to CHAMPS.

5. MDHHS regularly updates TPL information and checks claims and encounter data for proper reporting of TPL resources as part of the claim adjudication process.

F. MDHHS and PAHP payment liability for enrollees with other insurance is the lesser of the enrollee's liability (including coinsurance, copayments, or deductibles), the provider's charge minus contractual adjustments, or the maximum Medicaid fee screen minus the insurance payments.

G. The PAHP must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the PAHP's network provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the enrollee's file. When billing electronically, all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of the Medicaid Provider Manual.)

H. If payments are made by another insurance carrier, the amount paid, whether it is paid to the PAHP, rendering provider or the enrollee, must be reflected on the encounter claim. It is the PAHP's responsibility to obtain the payment from the enrollee if the other insurance pays the enrollee directly. It is acceptable to bill the enrollee in this situation. The PAHP may not bill the enrollee unless the enrollee is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the PAHP has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or

reimbursed to MDHHS Third Party Liability Section.

I. Insurance companies should not submit checks directly to Medicaid. Rather, the PAHP must work directly with the insurance company or the enrollee to obtain the insurance payment. If the insurance company pays the enrollee directly, it is the PAHP's responsibility to obtain the payment from the enrollee; if the policyholder is someone other than the enrollee, it is the PAHP's responsibility to obtain the payment from the policyholder.

J. The PAHP must submit an encounter claim replacement if another insurance makes a payment subsequent to the submission of the original encounter.

K. Claims subject to additional edits

1. If an enrollee has Medicare or private insurance, submitted claims must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered, prescribed or referred the service(s)/item(s).

2. If the applicable attending, ordering, prescribing or referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

L. Exceptions to Medicaid payer of last resort

1. There are a few exceptions to the general rule that Medicaid is the payer of last resort. In limited circumstances where there is a federal statute making Medicaid primary to a specific program, the Medicaid program must pay before the federally-administered health program.

2. The following federally-administered programs are some examples of exceptions to Medicaid's payer of last resort rule:

a. Crime Victims Compensation Fund
b. Ryan White Program
c. Indian Health Services
d. Women, Infants and Children Program
e. Grantees under Title V of the Social Security Act (Maternal and Child Health Services Block Grant)
f. Veteran Benefits – emergency treatment provided in a non-VA facility
g. Veteran Benefits – non-VA nursing home per diem payments
h. Older American's Act services
i.

XXII. Medicaid Provider Enrollment Requirements (42 CFR §438.602(b) and 42 CFR §438.608(b)

A. PAHPs must comply with requirements for enrollment of MI Choice providers into the CHAMPS system when MDHHS has the necessary system capability in place to accept these enrollments. Additional guidance will be forthcoming from MDHHS.

B. PAHPs 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.

XXIII. Non-Emergency Medical Transportation Requirements

A. Effective December 27, 2021, waiver agencies 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.

Each waiver agency 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 for MI Choice participants must meet minimum requirements.

The minimum requirements are:

1. 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 Health and Human Services; and

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

3. 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

4. Each provider and individual driver must disclose and report any felony conviction related to a controlled substance to the waiver agency; and

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

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

    a. More than two moving violations
    b. Operating While Intoxicated (OWI)
    c. Driving Under the Influence (DUI)

7. Exceptions to the traffic violation exclusion:

    a. A family member with any of the traffic convictions listed may receive reimbursement for NEMT provided to a MI Choice participant who is unable to

consent because of an intellectual or development disability or a legal guardianship, with the written consent of their legally responsible party.

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

8. Applicability:

a. These requirements **are not** applicable to a public transit authority.
b. These requirements **are not** applicable to the MI Choice participant.
c. These requirements **are** applicable to transportation network companies such as Uber or Lyft.
d. These requirements **are** applicable to a beneficiary's family members.
e. These requirements **are** applicable to taxicab drivers.

9. Additional Resources to Use

a. MDHHS Sanctioned Provider List (maintained by MDHHS)
b. Federal DHHS OIG exclusions

XXIV. Additional Requirements

A. This contract obligates the PAHP to require that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the serviced directly (i.e., no balance billing by providers).

B. The MI Choice Policy Chapter in the Michigan Medicaid Provider Manual identifies, defines, and specifies the amount, duration, and scope of each service the PAHP is required to offer.

C. This contract requires that any cost sharing imposed on MI Choice participants is in accordance with Medicaid fee-for-service requirements at 42 CFR §447.50 through 42 CFR §447.82.

D. The PAHP is required to exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian Health Care Provider (IHCP) or through referral under contract health services.

E. The PAHP is required to exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

F. This contract requires the state, the enrollment broker, or the PAHP to identify persons who need long-term services and supports (LTSS) as defined by the State.

G. If the PAHP provides LTSS in a community-based setting that could be authorized through a section 1915(c) waiver, the contract specifies that the long-term services and supports must be provided in a setting which complies with the 42 CFR §441.301(c)(4) requirements for home and community.