This Contract, effective September 24, 2014, re-executed on November 1, 2016 and January 1, 2018; amended by addendum effective January 1, 2019, is hereby amended by addendum effective September 1, 2020, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Michigan, acting by and through The Michigan Department of Health and Human Services (MDHHS), and the Michigan Department of Technology, Management and Budget, and _____ the Integrated Care Organization (ICO.) The ICO 's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, MDHHS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the Social Welfare Act, MCL 400.1 et seq., designed to pay for medical, behavioral health, and Long Term Supports and Services (LTSS) for eligible beneficiaries (Enrollee, or Enrollees);

WHEREAS, the ICO is in the business of providing medical services, and CMS and MDHHS desire to purchase such services from the ICO;

WHEREAS, the ICO agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, in accordance with **Section 5.8** of the Contract, MDHHS and the ICO desire to amend the Contract

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

1. This Addendum deletes **Subsection 4.1.2** and replaces it with the following **Subsection 4.1.2**:

    4.1.2 Demonstration Year Dates

    4.1.2.1. Capitation Payment updates will take place on January 1st of each calendar year or more frequently, as described in this section; however, savings percentages and quality withhold percentages (see Sections 4.2.3 and 4.4.4) will be applied based on Demonstration Years, as follows:

    4.1.2.1.1 Demonstration Year 1: March 1, 2015-December 31, 2016

    4.1.2.1.2 Demonstration Year 2: January 1, 2017-December 31, 2017

    4.1.2.1.3 Demonstration Year 3: January 1, 2018-December 31, 2018

    4.1.2.1.4 Demonstration Year 4: January 1, 2019-December 31, 2019

    4.1.2.1.5 Demonstration Year 5: January 1, 2020-December 31, 2020

    4.1.2.1.6 Demonstration Year 6: January 1, 2021-December 31, 2021

2. The Addendum deletes **Subsection 4.2.1.5** and replaces it with the following **Subsection 4.2.1.5**:

    4.2.1.5 Updates to the capitation rates component of the rate for Demonstration Years 2-6 will use updated information consistent with data utilized in the development of rates for Demonstration Year 1 with savings percentages applied.

3. This Addendum deletes **Subsection 4.2.3** and replaces it with the following **Subsection 4.2.3:**

    4.2.3 Aggregate Savings Percentages

    4.2.3.1 Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.2.3.3 or 4.2.3.4.

    4.2.3.1.1 Demonstration Year 1: 1%

    4.2.3.1.2 Demonstration Year 2: 2%

    4.2.3.1.3 Demonstration Year 3: 3%

4.2.3.1.4 Demonstration Year 4: 3%

4.2.3.1.5 Demonstration Year 5: 3%

4.2.3.1.6 Demonstration Year 6: 3%

4. This Addendum deletes **Subsection 4.3.1.2** and replaces it with the following **Subsection 4.3.1.2:**

"4.3.1.2 Risk corridors will not be applied for Demonstration Years 2-6.

5. This Addendum deletes **Subsection 4.3.2** and replaces it with the following **Subsection 4.3.2:**

4.3.2 Medical loss ratio (MLR)

4.3.2.1 Beginning Demonstration Year 2, each ICO will be required each year to meet a Minimum Medical Loss Ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments after final risk adjustment) that must be used for expenses either directly related to Covered Services or those which are related to the care of and quality improvement for Enrollees.

4.3.2.2 The ICO has a target MLR of eighty-five percent (85%) for Demonstration Years 1 through 5, and eighty-six percent (86%) for Demonstration Year 6.

4.3.2.3 If the MLR calculated as set forth below is less than the target MLR, the ICO shall refund to MDHHS and CMS an amount equal to the difference between the Actual MLR and the Target MLR (expressed as a percentage) multiplied by the coverage year revenue, as described below. MDHHS and CMS shall calculate a MLR for Enrollees under this Contract for each coverage year, and shall provide to the ICO the amount to be refunded, if any, to MDHHS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payer based on the proportion between the Medicare and Medicaid Components. At the option of CMS and MDHHS, separately, any amount to be refunded may be recovered either by requiring the ICO to make a payment or by an offset to future capitation or quality withhold payments. The MLR

calculation shall be determined as set forth below; however, MDHHS and CMS may adopt NAIC reporting standards and protocols after giving written Notice to the ICO.

4.3.2.3.1 For Demonstration Years 2 through 5, if the ICO has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the ICO, the ICO must remit the amount by which the eighty-five (85%) threshold exceeds the ICO's actual MLR multiplied by the total Capitation Payment revenue of the contract.

4.3.2.3.2 For Demonstration Year 6, in addition to remitting the amount by which the eighty-five percent (85%) threshold exceeds the ICO's MLR multiplied by the total Capitation Payment revenue, the ICO will also remit according to the following schedule:

4.3.2.3.2.1 In Demonstration Year 6, if the ICO's MLR is below eighty-six percent (86%), the ICO will remit fifty percent (50%) of the difference between its MLR and eighty-six percent (86%) multiplied by the total Capitation Payment revenue (if the ICO's MLR is above 85%) or 0.5% multiplied by the total Capitation Payment revenue (if the ICO's MLR is at or below 85%).

4.3.2.4 MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:

4.3.2.4.1 All Covered Services required in the Demonstration under Section 2.4 and Appendix A;

4.3.2.4.2 Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and

4.3.2.4.3 Care Coordination Expense. That portion of the personnel costs for ICO Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for ICO's medical director that is attributable to this Contract shall be included as a benefit expense.

4.3.2.5 The revenue used in the MLR calculation will consist of the Capitation Payments, as adjusted pursuant to Section 4.2.4, due from MDHHS

and CMS for services provided during the coverage year. For Demonstration Year 1, revenue will include amounts withheld pursuant to Section 4.4.4, regardless of whether the ICO actually receives the amount in Section 4.4.4. For Demonstration Years 2-6, revenue will reflect the actual amounts received by the ICO under Section 4.4.4.

4.3.2.6 Data Submission. The ICO shall submit to MDHHS and CMS, in the form and manner as well as on a schedule, prescribed by MDHHS and CMS, the necessary data to calculate and verify the MLR after the end of the coverage year.

4.3.2.7 Medical Loss Ratio Calculation. Following the submission of the MLR report, MDHHS and CMS will have sixty (60) days to review and finalize the MLR calculation. MDHHS and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. Subsequently, the ICO shall have sixty (60) calendar days to review the MLR calculation. Each party shall have the right to review all data and methodologies used to calculate the MLR.

4.3.2.8 Coverage Year. The coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available from the coverage year, including incurred but not paid and nine (9) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

4.3.2.9 Medicaid Medical Loss Ratio. If at any point for Medicaid rating periods beginning on or after July 1, 2017, the joint MLR covering both Medicare and Medicaid, as described in Section 4.3.1, ceases, the ICO is required to calculate and report their MLR experience for Medicaid consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74.

6. This Addendum deletes **Subsection 4.4.3.8** and replaces it with the following **Subsection 4.4.3.8:**

4.4.3.8 In Demonstration Years 2-6, CMS and the MDHHS will review the rates and payment parameters if two (2) or more ICOs show MLRs below ninety percent (90%) over all regions in which those ICOs participate, or in the event that two (2) or more ICOs show annual losses exceeding five percent (5%) over all regions in which those ICOs participate.

7. This Addendum deletes **Subsection 4.4.4.5** and replaces it with the following **Subsection 4.4.4.5:**

4.4.4.5 Whether or not each ICO has met the quality requirements in a given year will be made public, as will relevant quality results of ICOs in Demonstration Years 2-6.

8. This Addendum deletes **Subsection 4.4.4.8** and replaces it with the following **Subsection 4.4.4.8:**

4.4.4.8 Withhold Measures in Demonstration Years 2-6

4.4.4.8.1 The quality withhold will increase to two percent (2%) in Demonstration Year 2, three percent (3%) in Demonstration Years 3-5, and four percent (4%) in Demonstration Year 6.

4.4.4.8.2 Payment will be based on performance on the quality withhold measures listed in Exhibit 7 below. The ICO must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.4.4.8.3 If the ICO is unable to report at least three of the quality withhold measures listed in Exhibit 7 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Exhibit 7 Quality Withhold Measures for Demonstration Years 2-6

Measure	Source	CMS Core Withhold Measure	Error! Use the Home tab to apply State Name to the text that you want to appear here. Withhold Measure
Encounter Data	CMS defined measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	
Annual Flu Vaccine	AHRQ/CAHPS	X	

Measure	Source	CMS Core Withhold Measure	Error! Use the Home tab to apply State Name to the text that you want to appear here. Withhold Measure
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Care Transition Record Transmitted to Health Care Professional	CMS/State defined measure		X
Medication Review – All Populations	State-defined (HEDIS-like)		X
Documentation of Care Goals (DY 2-5 only)	CMS/State defined measure		X
Urinary Tract Infection (DY 2-3 only)	CMS/State defined measure		X
Annual Dental Visit (DY 4-6 only)	CMS/State defined measure		X
Minimizing Institutional Length of Stay (DY 6 only)	CMS/State defined measure		X
Antidepressant Medication Management – Effective Acute Phase Treatment (DY 6 only)	NCQA/HEDIS		X
Colorectal Cancer Screening	NCQA/HEDIS		X

Measure	Source	CMS Core Withhold Measure	Error! Use the Home tab to apply State Name to the text that you want to appear here. Withhold Measure
(DY 6 only)			
Medication Reconciliation Post-Discharge (DY 6 only)	NCQA/HEDIS		X

9. This Addendum deletes **Subsection 5.7.1.1** and replaces it with the following **Subsection 5.7.1.1:**

   "5.7.1.1. This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2021, so long as the ICO has not provided CMS and the Department with a Notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5, above.

10. This Addendum deletes **Appendix K** and replaces it with the following **Appendix K**:

    Appendix K: Additional Medicare Waivers

    In addition to the waivers granted for the MI Health Link demonstration in the MOU, CMS hereby waives:

    K1. Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)(4)(i), and extend Sections 1851 (a), (c), (e), and (g) of the Social Security Act, as implements in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

    K2. Section 1851(d) of the Social Security Act and the implementing regulations at 42 C.F.R. § 422, Subpart C, only insofar as such provisions are inconsistent with the network adequacy processes provided under the Demonstration.

In Witness Whereof, CMS, the State of Michigan, and the ICO have caused this Agreement to be executed by their respective authorized officers:

TYPE NAME AND TITLE HERE	Date

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In Witness Whereof, CMS, MDHHS, and the ICO have caused this Agreement to be executed by their respective authorized officers:

Jared Ambrosier	Date
Director, Enterprise Sourcing	
Central Procurement Services - Enterprise Sourcing	
State of Michigan	

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In Witness Whereof, CMS, the State of Michigan, and the ICO have caused this Agreement to be executed by their respective authorized officers:

Kate Massey Date

Senior Deputy Director, Medical Services Administration

Michigan Department of Health and Human Services

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In Witness Whereof, CMS, the state of Michigan, and the ICO have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Shantrina Roberts Date

Deputy Director, Division of Managed Care Operations

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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In Witness Whereof, CMS, the State of Michigan, and the ICO have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Kathryn Coleman Date

Director

Medicare Drug & Health Plan Contract Administration Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services