Form No. DTMB-3521 (Rev. 7/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 15

to

CONTRACT NO. 071B0200018

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
Aetna Better Health of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	PHONE	CONTRACTOR'S TAX ID NO. (LAST FOUR DIGITS ONLY)
Detroit, MI 48207	313-465-1519	2897

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER / CCI	DHHS	Kevin Dunn	517-335-5096	dunnk3@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	517-284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY

DESCRIPTION: Comprehensive Health Care Program - DHHS (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, 1 Year	December 31, 2015

PAYMENT TERMS	DELIVERY TIMEFRAME
Net 45	N/A

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

EXERCISE OPTION?	LENGTH OF OPTION	EXERCISE EXTENSION?	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$1,258,550,734.69	N/A	$1,258,550,734.69

DESCRIPTION: Effective immediately, Attachment B, Contractor's Awarded Rates, is hereby amended to include the following language. All other terms, conditions, specifications, and pricing remain the same. Per agency and contractor agreement and DTMB Procurement approval.

Contract Changes Mid-Year FY 2015
Contract Changes Effective 10/1/2014, 1/1/2015 and 4/1/2015

Attachment B, Contractor's Awarded Rates, is hereby amended to include the following:

Fiscal Year 2015

The State of Michigan Fiscal Year 2015 Managed Care Rates for the Comprehensive Health Care Program, effective October 1, 2014, through September 30, 2015, will be paid within the certified, actuarially sound rate range. Managed Care Rates for the Healthy Michigan Plan, effective April 1, 2014 – March 31, 2015, will be paid within the certified, actuarially sound rate range. If rates require recertification during the contract year, a contract amendment will be issued. Certified rates and adjustments for the Comprehensive Health Care Program and Healthy Michigan Plan (HMP) were distributed via e-mail on July 10, 2015, and are incorporated herein by reference.

Rates were adjusted for all Medicaid programs to reflect changes in reimbursement for professional services at January 1, 2015.

HMP rates were updated to reflect the impact of provider reimbursement changes on the maternity case rate at October 1, 2014. HMP rates also include an additional administrative load of 0.5% at January 1, 2015. Rates for the HMP were originally certified for the 12 month time period from April 1, 2014 – March 31, 2015, and have been updated at the following three quarters for subsequent reimbursement and tax changes. HMP rates are fully recertified at April 1, 2015.

Form No. DTMB-3521 (Rev. 2/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 14

to

CONTRACT NO. 071B0200018

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
Aetna Better Health of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	PHONE	VENDOR TAX ID # (LAST FOUR DIGITS ONLY)
Detroit, MI 48207	(313) 465-1519	2897

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Kevin Dunn	(517) 335-5096	dunnk3@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	(517) 284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY

DESCRIPTION:
Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2015
PAYMENT TERMS	F.O.B.	SHIPPED TO	
N/A	N/A	N/A	

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS
N/A

DESCRIPTION OF CHANGE NOTICE

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF EXTENSION/OPTION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☐	☒	3 months	December 31, 2015

CURRENT VALUE	VALUE/COST OF CHANGE NOTICE	ESTIMATED REVISED AGGREGATE CONTRACT VALUE
$1,251,789,257.69	$6,761,477.00	$1,258,550,734.69

DESCRIPTION:
Effective April 28, 2015, the attached documents are hereby incorporated into this contract and the contract increased by $6,761,477.00. The contract expiration date has been revised to December 31, 2015.

All other terms, conditions, specifications, and pricing remain the same. Per agency and vendor agreement, DTMB Procurement approval and the approval of the State Administrative Board on April 28, 2015.

Appendix 2

DCH Financial Monitoring Standards

Reporting Period	Monitoring Indicator	Threshold	DCH Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	DCH written notification	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance
Quarterly Financial	Net Worth	Negative Net Worth	DCH written notification Freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	150-200% RBC	DCH written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	100-149% RBC	DCH written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

Appendix 3
2015 Reporting Requirements for Medicaid Health Plans

All reports must be **shared** electronically via the **DCH File Transfer Application**.
Exceptions are the encounter data, provider file, and PCP Submission file which are submitted electronically via the DEG.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Consolidated Annual Report	3/15/15	1/1/14 – 12/31/14	Contract 1.042A(2)
• Health Plan Profile (MSA 126 (01/06)) NOTE: **Follow instructions carefully and include all required attachments.** • Financial (NAIC, all reports required by DIFS, and Statement of Actuarial Opinion are due with the annual report on 3/15/15). *NOTE: The Management Discussion and Analysis is due 4/15/15 and the Audited Financial Statements are due 6/15/15.* • Health Plan Data Certification Form (MSA 2012 (03/13)). • Litigation (limited to litigation directly naming health plan, MSA 129 (09/99)) • Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms) • Provider Manual, Certificate of Coverage, Member Handbook (WR only) • EPSDT Requirements: o **Incentives:** List, with brief description, member incentives offered to increase member utilization of EPSDT services; List, with brief description, provider incentives offered to increase monitoring of/providing EPSDT services			
Michigan Medicaid Tobacco Cessation Benefits Grid	6/15/15	Current, up-to-date, per contract	1.022 F (20) Use MI Medicaid Tobacco Cessation Benefits Grid as provided by DCH in January
Management Discussion and Analysis for Annual Financial	4/15/15	1/1/14 – 12/31/14	Contract 1.042 A(2)
Audited Financial Statements	6/15/15	1/1/14 – 12/31/14	NAIC, DIFS
QIP Annual Evaluation and Work Plan	6/15/15	Current, Approved 2014 Evaluation, 2015 Work Plan	Electronic Format; Contract 1.022 Z(1-3)
Medicaid Health Equity Template	8/15/15	1/1/14 – 12/31/14	Use the template provided by DCH in March
HEDIS® Compliance Audit – Final Audit Report	8/15/15	1/1/14 – 12/31/14	NCQA formatted, electronic copy
HEDIS® IDSS	7/15/15	1/1/14 – 12/31/14	NCQA formatted, electronic copy
• Auditor-locked Excel format Audit Review Table (ART) • Excel Downloads: Comma Separated Values (CSV) Workbook • Excel Downloads: Data-filled Workbook (measure level detail file), and • Copy of MHP's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter			
Quarterly Submissions			
Financial	5/15/15 8/15/15 11/15/15	1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	NAIC and DIFS

Report Reference	Due Date	Period Covered	Instructions/Format
Grievance/Appeal	1/30/15 4/30/15 7/30/15 10/30/15	10/1/14 – 12/31/14 1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	MSA 131 (11/11), Grievance & Appeal Report
Third Party Collection	5/15/15 8/15/15 11/15/15	1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	Report on separate sheet and send with NAIC
Monthly Submissions			
Claims Processing	30 days after end of the month NOT last day of month	• Data covers previous month • i.e., data for 2/15 due by 3/30/15	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/15 due by 2/15/15	837 Format NCPDP Format
Provider Files (4275)	Friday before the last Saturday of each month	• Submit all providers contracted with the plan on the date of submission • Submit four files, utilizing the provider voluntary ID for Benefit Plans: *MA-MC *CSHCS-MC *MME-MC *HMP-MC	4275 layout and file edits distributed by DCH
PCP Submission Files (5284)	Weekly if PCP name is NOT on ID card; otherwise at least one monthly	•Submit all new and end-dated PCP relationships since the previous submission •Submit a complete refresh file during the time period required by DCH	5284 layout and file edits distributed by DCH
Health Risk Assessment File (5708)	At least one file prior to the 20th of each month	Once the initial appointment is complete, plans will have 60 days to transmit the associated HRA data to DCH via the 5708 file layout.	5708 Layout and file edits distributed by DCH

MEDICAID MANAGED CARE
Medicaid Health Plans
(Contract Year October 1, 2014 – September 30, 2015)

Appendix 4 - PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE)**.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the measurement Period.	Informational Only	MDCH Data Warehouse	Quarterly
• **Quality of Care:** Elective Delivery	Pregnant women with elective vaginal deliveries or elective cesarean sections at between 37 and 39 weeks completed gestation.	Informational Only	MDCH Data Warehouse	Quarterly
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	Informational Only	MDCH Data Warehouse	Quarterly
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥81% continuous enrollment	MDCH Data Warehouse	Quarterly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	Informational Only	MDCH Data Warehouse	Quarterly
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during measurement period.	Informational Only	MDCH Data Warehouse	Quarterly
• **Access to care:** Adult Access to Preventive/Ambulatory Health Services	Adults 20+ years who had an ambulatory or preventive visit during the measurement period	Informational Only	MDCH Data Warehouse	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Customer Services:** Enrollee Complaints	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate ≤0.15 per 1000 member months	Customer Relations Management (CRM)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims processed within 30 days, ≤1% of ending inventory over 45 days old; ≤12% denied claims	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Accurate submission	MI Enrolls	Monthly

Appendix 5
2015 Bonus Measures Template
DCH Pay for Performance—Healthy Michigan Plan Systems

In an effort to ensure consistency among plans in tracking and reporting FY16 metrics related to Healthy Michigan Plan, the FY15 Focus Bonus is a review of processes, procedures, and systems that will be utilized in the generation of these metrics.

There are three domains of review that draw from 40% of the total capitation withhold pool: 1) Cost sharing and incentives. 2) Access to Care. 3) Health Risk Assessment.

The Value Added section draws from 10% of the total capitation withhold pool.

Instructions: Email all documents to Nneka LaBon at labonn@michigan.gov. The subject line should be labeled as 2015P4P- Category name (ex. 2015P4P – Access).

Category	Criteria/Deliverables
1. **Cost Sharing and Incentives** (15 points)	1. October 1, 2014. A contract with the MI Health Account vendor, Maximus, will be signed and in place. 2. April 1, 2015. Description of ongoing monitoring of MI Health Account vendor, Maximus, in relation to: a. Required three reports related to cost sharing b. Member education on cost-sharing responsibilities including welcome letter, statements, and payment coupons c. Investigation of MIHealth Account complaints received by Maximus 3. December 1, 2014. Member Incentive. A Policy/Procedure will be submitted to DCH that outlines the MHP process for members receiving an incentive. This will include, at a minimum, the following: a. The process of receiving and processing completed Health Risk Assessments and identifying which members are eligible for incentives including HRAs completed during the FFS period b. The process to 'flag' those members for an incentive in the MIS/administrative system c. A congratulatory letter that is approved by DCH that informs members that they have earned an incentive and turnaround time for distribution of the letter and/or gift card. 4. December 1, 2014. Provider incentive. A Policy/Procedure will be submitted to DCH that outlines the MHP process for physician incentives. 5. Encounter Quality Initiative submissions in accordance with dates provided by MDCH. a. Follow-up explanation of variances for each submission in a summary email to MDCHEncounterData@michigan.gov b. Available for at least one annual site visit from DCH staff
2. **Access to Care** (10 points)	1. December 1, 2014. Assistance with scheduling first primary care appointment. Documentation will be submitted to DCH that outlines how MHP encourages and assists members with scheduling and attending first primary care appointment. 2. April 1, 2015. Report of transportation services provided to HMP members. MDCH will pull this from encounter data.

	3. June 1, 2015. Network adequacy. Number of PCPs with evening and weekend appointments available. MDCH will pull this from the 4275 file.
3. **Health Risk Assessment** (15 points)	1. October 20, 2014. First HRA survey file (5708) to DCH. MHP will submit a monthly HRA survey file (5708) to DCH by the 20th of each month. 2. December 1, 2014. HRA survey file (5700) from Maximus. A Policy/Procedure will be submitted to DCH that outlines the MHP process for receiving the HRA survey file (5700). 3. December 1, 2014. HRA survey file (5708) to DCH. A Policy/Procedure will be submitted to DCH that outlines the MHP process for submitting the HRA survey file (5708) and including process for resending record rejections identified in HRA survey error file (5725). 4. December 1, 2014. Member Education. A Policy/Procedure will be submitted to DCH that outlines the MHP process for educating members about the Health Risk Assessment. This must include HRA in welcome packet, member education about healthy behaviors incentives and HRA information in new member call script. 5. March 1, 2015. Assistance with Healthy Behaviors. A Policy/Procedure will be submitted to DCH that outlines the MHP process for identifying members who have identified health risk reduction goals on HRA and outreach to these members. a. Report of members reached and documentation of support services, education, or other interventions provided by MHP.
4. **Value added** (10 points)	Cost Sharing and Incentives Value Added 1. Documentation of additional efforts to inform members of copays and contribution responsibilities in handbook, newsletter, etc. 2. Documentation of additional efforts to encourage members to meet their cost-sharing obligations beyond responsibilities outlined in contract with the MI Health Account vendor Access to Care Value Added 3. Documentation of assistance with picking a Primary Care Provider offered in initial outreach call 4. Documentation of assistance with transportation needs offered in initial outreach call HRA Value Added 5. Documentation of provider education on correct Health Risk Assessment completion, including accessing and submitting the HRA information

Contract Changes FY 2015
Contract Changes are Effective 10/01/2014

1. Tobacco Cessation

Section 1.022(F)(20), final paragraph is hereby replaced in its entirety with the following:

The Contractor may not place prior authorization requirements on over-the-counter agents or prescription inhalers or nasal sprays. Further, DCH encourages the Contractor to have no co-payment or prior authorization requirements for the remaining tobacco cessation treatments. However, the Contractor may place a reasonable limit on the type and frequency of over-the-counter and prescription agents covered under this benefit. The Contractor may also require prior authorization for prescription drugs other than inhalers or nasal sprays. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

2. Health Education

The following paragraph is hereby removed from 1.022H(1) Enrollee Services – General

Written and oral materials directed to enrollees, relating solely to health education, may be filed with DCH a minimum of 10 business days prior to use. If DCH does not respond to the filing within 10 business days the material is deemed approved.

3. Healthy Michigan Plan Enrollee Healthy Behaviors and Health Risk Assessment

Section 1.022H(6) Enrollee Services, the second paragraph is replaced in its entirety with the following:

Contractors must ensure that all HMP enrollees have an opportunity to complete a health risk assessment annually and receive the first health risk assessment upon initial enrollment with an MHP Contractor. Contractors must utilize the DCH-approved Health Risk Assessment (HRA) protocol. MI Enrolls will conduct the initial HRA for HMP enrollees via the telephone at the time of enrollment with the Contractor. The HRA results will be transmitted via a secure gateway to the Contractor.

4. Explanation of Benefits

Section 1.022(O)(2) Program Integrity final paragraph is hereby replaced in its entirety with the following:.

The Contractor is required to provide Explanation of Benefits (EOBs) to a minimum of 5% of the enrollees receiving services. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution during the compliance review process

5. Program Integrity

Section 1.022(O)(3) Reporting is hereby replaced in its entirety with the following:

At the time of suspicion, the Contractor must report/refer <u>all</u> (employee, providers and members) suspected of fraud or abuse to Office of Health Services Inspector General (OHSIG) via email (dch-oig@michigan.gov), online (michigan.gov/fraud), or through mail delivery to PO Box 30062, Lansing, MI 48909. The report/referral must include, at minimum:

- Subject (name, address, phone number, member Medicaid identification number, provider NPI and type, and any other identifying information)
- Source/origination of the complaint
- Date reported/referred to OHSIG
- Nature of the complaint including, but not limited to:
    - Type of service
    - Factual explanation of the suspected fraud/abuse
    - Medicaid statutes, rules, regulations, or policies violated
    - Dates of suspected fraud or abuse

- Approximate range of dollars involved
- Amount paid on behalf of a member or to a provider during the past three years or during the period of the suspected fraud or abuse, whichever is greater
- Encounter claims for the amount paid on behalf of a member or to a provider during the past 3 years or during the period of the suspected fraud or abuse, whichever is greater
- All communications between the Contractor and member or provider concerning the suspected fraud or abuse
- Contact information for Contractor staff person with the most knowledge relating to the report/referral
- Legal and administrative disposition of the case, <u>including actions taken by law enforcement officials to whom the case has been referred</u>
- Any and all documentation, data, or records obtained, reviewed, or relied on by the Contractor leading to the suspicion of fraud or abuse including but not limited to:
    - Beneficiary/Patient files
    - Audit reports and findings
    - Medical Necessity reviews and the reviewing personnel

Additionally, the Contractor must provide the numbers and details of program integrity activities performed quarterly. These activities fall into four categories – tips/grievances, data mining/algorithms, audits, and provider disenrollment's. Activities performed January through March must be reported by May 1; activities performed April through June must be reported by August 1; activities performed July through September must be reported by November 1; and activities performed October through December must be reported by February 1. Program integrity activities must be reported to OHSIG in the format developed by the State. A Contractor not initiating any data mining activities or performing any audits within a given quarter will receive a failing grade for that quarter's submissions.

The Contractor shall disclose to OHSIG the names and NPI numbers of providers being placed on prepayment review at the time the provider is placed on prepayment review status. The Contractor's shall include in such disclosure the following:

- The date of the prepayment review was initiated
- The reason for the prepayment review

The data or information relied on in placing the provider on prepayment review. The Contractor must inform OHSIG of actions taken to investigate or resolve the reported suspicion, knowledge, or action. The Contractor must also cooperate fully in any investigation by OHSIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

The Contractor is permitted to disclose protected health information to OHSIG without first obtaining authorization from the enrollee to disclose such information, and is required to make such disclosures upon OHSIG's request without requiring the service of process. The Contractor is also permitted to disclose protected health information to the Department of Attorney General without first obtaining authorization from the enrollee to disclose such information. OHSIG and the Department of Attorney General shall ensure that such disclosures meet the requirements for disclosure made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.50.

6. MIS Capability

Section 1.022P(2), the second sentence is hereby amended to include the following:

(g) Collecting enrollee income, group composition, and federal poverty level information for HMP enrollees

7. Performance Bonus
   Section 1.062(B) is hereby replaced in its entirety with the following:

   During each Contract year, DCH will withhold .0019 of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

   DCH will establish a separate Targeted Performance Incentive Award. Funds allocated to this award will be distributed in equal proportions to each qualifying Contractor. DCH will establish the criteria used to distribute this award to Contractors. DCH will establish the percentage of the withhold funds to be allocated to the performance bonus template and the percentage to be allocated to the Targeted Performance Incentive Award. DCH will communicate the established percentages to the Contractor prior to the start of each fiscal year.

8. Payment Option
   Section 1.062C is hereby removed in its entirety.

9. Appendix 2
   Appendix 2 is hereby replaced in its entirety with the attached.

10. Appendix 3
    Appendix 3 is hereby replaced in its entirety with the attached.

11. Appendix 4
    Appendix 4 is hereby replaced in its entirety with the attached.

12. Appendix 5
    Appendix 5 is hereby replaced in its entirety with the attached.

13. Attachment B Fiscal Year 2015
    Attachment B is hereby amended to include the following new section

    Update to Fiscal Year 2015

    Effective 1/1/2015, the Medicaid Health Plan rates will be modified in accordance with Section 1801 of PA 252 of 2014. This change will require the Medicaid Health Plans to continue a portion of the Primary Care Physician Incentive Payment Program which increases Medicaid rates for certain primary care services provided only by primary care providers.

    Fiscal Year 2015

    The State of Michigan Fiscal Year 2015 Managed Care Rates, effective October 1, 2014 through September 30, 2015, will be paid within the certified, actuarially sound rate range. If rates require recertification during the contract year, a contract amendment will be issued. The rates for Fiscal Year 2015 will be distributed under separate cover and are incorporated herein by reference.

Retroactive Contract Changes FY 2014
Contract Change is Effective 4/01/2014 and 07/01/2014 respectively

14. Attachment B Fiscal Year 2014
    Attachment B is hereby amended to include the following new section.

    Update to Fiscal Year 2014

    In accordance with amendment to PA 94 of 1937, the Medicaid Health Plan rates are retroactively increased to include reimbursement relative to a 5.98% tax on the use and consumption of medical services. The change is effective 4/1/2014.

    Additionally, the rates were modified effective 7/1/2014 in accordance with amendments to PA 142 of 2011 which reduced the Health Insurance Claims Assessment from 1.0% to .75%, retroactively effective 7/1/2014.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 13
to
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Aetna Better Health of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MDCH	Kevin Dunn	(517) 335-5096	dunnk3@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2015
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$1,251,789,257.69

Effective November 17, 2014, this contract has been updated to show that the vendor name has changed to Aetna Better Health of Michigan, Inc. All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement and DTMB Procurement approval.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 12
to
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
CoventryCares of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MDCH	Kevin Dunn	(517) 335-5096	dunnk3@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2014
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS	
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐		September 30, 2015

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$295,470,351.00	$1,251,789,257.69

Effective April 1, 2014, the CCI has been updated, the attached Contract changes for Mid Fiscal Year 2014 are hereby incorporated into this Contract and the Contract is increased by $295,470,351. The Contract expiration date has been revised to September 30, 2015.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement,

DTMB Procurement approval, and State Administrative Board approval on March 25, 2014.

Mid-Year Contract Changes FY 2014
Contract Changes are Effective 4/01/2014

Section A: MDCH Initiated Changes

1. Medicare HMO exclusion

   Section 1.022(A) paragraph three, bullet # 5 is hereby replaced in its entirety with the following:

   - Persons with commercial HMO/PPO coverage

2. Marketing Incentives

   Section 1.022(H) (2) (Marketing Incentives) is hereby replaced in its entirely with the following:

   The Contractor is encouraged to provide member incentives to encourage adult beneficiaries to get an annual preventive visit that includes the four health screenings recommended as part of the Michigan 4 X 4 plan:

   - Body Mass Index (BMI)
   - Blood Pressure
   - Cholesterol Level
   - Blood Glucose Level

   The member incentives must meet all requirements for incentives.

3. Tobacco Cessation

   Section 1.022(F) (20) (Tobacco Cessation) is hereby replaced in its entirety by the following:

   The Contractor must provide covered tobacco cessation treatment that includes, at a minimum, the following services:

   (a) Intensive tobacco use treatment through a DCH approved telephone quit line
   (b) Group and/or individual counseling/coaching for tobacco cessation treatment separate from the 20 outpatient visits
   (c) Prescription Inhaler or Nasal Spray used to promote tobacco cessation
   (d) The following over-the-counter agents used to promote tobacco cessation
      i. Patch
      ii. Gum
      iii. Lozenge
   (e) At least one prescription of non-nicotine medication used to promote tobacco cessation
   (f) Counseling/coaching in conjunction with medication used to promote tobacco cessation
   (g) Combination Therapy - Use of a combination of medications used to promote tobacco cessation including, but not limited to, the following combinations that have been found to be most effective:
      i. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum and spray)
      ii. The nicotine patch and the nicotine inhaler
      iii. The nicotine patch and bupropion SR

   DCH encourages the Contractor to have no co-payment or prior authorization requirements for tobacco cessation treatment. However, the Contractor may place a reasonable limit on the type and frequency of over-the-counter and prescription agents covered under this benefit. The Contractor may also require prior authorization for prescription drugs. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

4. Annual Report

Section 1.042A (2) (g) (Annual report) is hereby amended to include the following:

. Transportation Information: The Contractor must provide all information requested on transportation expenses and utilization in the manner agreed upon by DCH in consultation with the Contractor

Medicaid Provider Directory: The Contractor must provide an electronic copy of the Medicaid Provider Directory that is effective on the date the annual report is submitted to DCH

5. Clarification of Excluded Services

Definitions Section is hereby amended to include the following:

Experimental/Investigational	For the purposes of the Contract with regard to pediatric oncology, an experimental/investigational drug, biological agent or procedure is one which has been determined by the Medical Services Administration, in consultation with appropriate subspecialist providers and the Contractor's Medical Director, based on qualified medical advice, that has not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used

6. Provider Incentives for 4 X 4

Section 1.022Q (10) (Provider Incentives for 4 X 4) is hereby amended to include the following:

Develop and implement provider incentives to encourage primary care providers to track patient screenings for the 4 key health indicators specified in the Michigan 4 X 4 plan:

- Body Mass Index (BMI)
- Blood Pressure
- Cholesterol Level
- Blood Glucose Level

Section B: Healthy Michigan Plan Changes:

7. Definitions

Definitions section is hereby amended to include the following:

ABW	Adult Benefit Waiver
Adult Benefit Waiver	Demonstration 1115 waiver from Center from Medicaid and Medicare Services that created the Adult Benefit Waiver Program that provided health care benefits under Title XIX of the Social Security Act to childless adult residents of the State of Michigan with income levels at or below 35% of the federal poverty level
Habilitative Service	Service that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Risk Assessment	Protocol approved by DCH to measure readiness to change and specific healthy behaviors of HMP enrollees

Healthy Michigan Plan	Program operated under an 1115 Waiver approved by CMS to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of federal poverty level.
HMP	Healthy Michigan Plan
HRA	Health Risk Assessment
Initial Enrollment	First enrollment in Medicaid Health Plan following determination of eligibility; re-enrollment in a Medicaid Health Plan following a gap in eligibility of less than two month is not considered initial enrollment.
MI Health Account	An account operated by the Contractor or the Contractor's vendor into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses

8. Transition of the Adult Benefit Waiver (ABW) Population-Twenty Visit Mental Health Outpatient Benefit

Section 1.022F (16) (Twenty Visit Mental Health Outpatient Benefit) is hereby replaced in its entirety by the following:

(16) Twenty Visit Mental Health Outpatient Benefit

The Contractor must provide a maximum of 20 outpatient mental health visits within a calendar year consistent with the policy and procedures established by Medicaid Policy. Services may be provided through contracts with Community Mental Health Services Programs (CMHSP), Pre-paid Inpatient Hospital Plans (PIHPs), or through contracts with other appropriate providers within the service area. Special conditions apply to Healthy Michigan Plan enrollees transitioning from the Adult Benefit Waiver receiving services from licensed PIHP providers at the time of enrollment for mild to moderate mental health conditions. The Contractor must allow these enrollees to continue to receive services from the established provider until the 20 visit maximum has been reached or the course of treatment is completed. If the PIHP provider is out-of-network, the Contractor must pay the provider at the Medicaid fee-for-service rate.

9. Healthy Michigan Plan Enrollees Transitioning from Adult Benefit Waiver

Section 1.022F has been amended to include subsection (23)

(23)Healthy Michigan Plan Enrollees Transitioning from Adult Benefit Waiver

Special conditions apply to enrollees in the Contractor's health plan enrolled in the Healthy Michigan Plan (HMP) who transitioned from the Adult Benefit Waiver. If the enrollee has an established relationship with a primary care provider at the time of enrollment in the health plan, the Contractor must allow the enrollee to continue to receive services from this provider. If the established primary care provider is out of network, the Contractor must allow the enrollee to continue with the out-of-network primary care provider for at least 30 days from the effective date of enrollment. After 30 day, the Contractor may transition the enrollee to an in-network provider when it is safe to transition care from the out-of-network provider. If the enrollee is engaged in an active course of treatment with an out-of-network specialty provider, the Contractor must allow the enrollee to complete the course of treatment. The Contractor may not move the enrollee to an in-network specialty provider until the course of treatment is completed and it is safe for the enrollee to change specialty providers.

Contractors are encouraged to seek contracts with out-of-network primary and specialty care providers with established relationships with these enrollees before moving the enrollee to an in-network provider. If the primary or specialty care provider does not wish to join the Contractor's network, the Contractor should work with the non-contracted provider on care coordination, prior

authorization and medical management until the enrollee can be safely brought into network. If a non-contracted primary care or specialty care provider declines the Contractor's offer to participate in the plans network and refuses to coordinate with the Contractor's case management team on prior authorization and medical management, the Contractor may move the enrollee to a network provider. In the event that the Contractor does not have a contract with the provider, all claims should be paid at the Medicaid FFS rate.

In order to preserve continuity of care for ancillary services, such as therapies, non-custom fitted durable medical equipment and medical supplies, Contractors must utilize prior authorizations in place when the HMP enrollee is enrolled with the Contractor's plan for at least 30 days from the effective date of enrollment. After 30 days from enrollment the Contractor must maintain the existing prior authorization or complete the Contractor's prior authorization process so that there is not gap in prior authorizations for medically necessary covered services. The Contractor must assure no interruption or delay of treatment, equipment or supplies while the Contractor establishes prior authorization. If the prior authorization is with a non-network ancillary provider, Contractors must reimburse the ancillary provider at the Medicaid rate. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment for the custom-fitted durable medical equipment.

10. Contributions and MI Health Account – Healthy Michigan Plan Enrollee Contributions

Section 1.022(H) (Enrollee Services) is hereby amended to include a new subsection (5):

(5) Healthy Michigan Plan Enrollee Contributions

As established 107 P.A. 2013, HMP enrollees with incomes above 100% of the federal poverty level must contribute 2% of their income annually to their health care costs. As allowed by 107 P.A. 2013, DCH has delegated operation of MI Health Accounts to the Contractor. The Contractor must establish and maintain a contract with the DCH-designated MI Health Account Vendor. The Contract must include, at a minimum, the following provisions:

- Statement of work
- Term of contract
- Termination provisions
- Payment provisions
- Dispute resolution

HMP enrollees will not have a required contribution for six months after enrollment with the first Contractor upon gaining HMP eligibility. Transfer from one Contractor to another Contractor after initial enrollment will not impact enrollee contribution requirements.

The MI Health Account Vendor must make all reasonable efforts to collect the enrollee contribution and must provide a variety of means by which the enrollee may remit the contribution, including but not limited to cash, money order, and arrangements with vendors for collection and electronic transmittal. Enrollees may not be disenrolled for failure to remit required contributions.

The contributions will be collected and operated in an account called the MI Health Account. The MI Health Account Vendor must establish, implement and operate the MI Health Accounts in accordance with this contract and the CMS-approved Operational Protocol for the MI Health Account which will be developed in consultation with the Contractor. The MI Health Account Vendor must comply with all requirements in the protocol.

The MI Health Account Vendor must issue quarterly statements for the MI Health Account. The quarterly statements must include the following:

- Expenditures from the account

- Contribution and co-payment amounts received
- Account balance
- Annual contribution amount
- Contribution and co-payment amount due for the next quarter.

The statement must comply with federal law and Medicaid policy with regard to services excluded from the statement.

11. Contributions and MI Health Account – MIS Capabilities

Section 1.022P is replaced in its entirety with the following:

(1) MIS Capability

The Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by DCH. The information system must have the capability for:

(a) Collecting and tracking enrollee-specific Health Risk Assessment information and providing the information to DCH in the specified format

(b) Collecting and tracking enrollee-specific healthy behavior and goal information for HMP enrollees and providing information to DCH in the specified format

(c) Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by DCH through an encounter data system

(d) Collecting data to monitor services provided to enrollees on the measurement of the following key indicators:
- Body Mass Index (BMI)
- Blood Pressure
- Cholesterol Level
- Blood Glucose Level

(e) Supporting provider payments and data reporting between the Contractor and DCH

(f) Controlling, processing, and paying providers for services rendered to Contractor enrollees

(g) Collecting service-specific procedures and diagnosis data, collecting price-specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintaining detailed records of remittances to providers

(h) Supporting all Contractor operations, including, but not limited to, the following:
   i. Member enrollment, disenrollment, and capitation payments, including the capability of reconciling enrollment and capitation payments received
   ii. Utilization
   iii. Provider enrollment
   iv. Third party liability activity
   v. Claims payment
   vi. Grievance and appeal tracking, including tracking for CSHCS enrollees separately

(2) Enrollment Files

DCH will provide HIPAA compliant weekly and monthly enrollment files to the Contractor via the Data Exchange Gateway (DEG). The Contractor's MIS must have the capability to utilize the files to update each enrollee's status on the MIS. The Contractor is required to load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's vendors (i.e. pharmacy, vision, behavioral health, DME) on or before the first of the month so that enrollees have access to services. Enrollees defined as "pending negative action" on the audit file should be reflected as enrolled on the Contractor's system until the monthly update file is received. After the receipt of the monthly update file, enrollees designated as "pending negative action" on the audit file who have lost eligibility or enrollment may be terminated on the Contractor's MIS. The Contractor must ensure that MIS support staff have sufficient training and experience to manage files DCH sends to the Contractor via the DEG.

(3) Data Accuracy

The Contractor must ensure that data received from providers is accurate and complete by:

(a) Verifying the accuracy and timeliness of the data
(b) Screening the data for completeness, logic, and consistency
(c) Collecting service information in standardized formats
(d) Identifying and tracking fraud and abuse

(4) Automated Contact Tracking System

The Contractor is required to utilize the Department's Automated Contact Tracking System to submit the following requests:

(a) Disenrollment requests for out of area members who still appear in the wrong county on the Contractor's enrollment file
(b) Request for newborn enrollment for out of state births or births for which DCH does not notify the Contractor of the newborn's enrollment within two months of the birth
(c) Maternity Case Rate (MCR) Invoice Generation request for births for which the Contractor has not received an MCR payment within three months of the birth
(d) Requests to place enrollees in the Benefits Monitoring Program; this requirement will be phased out as the new Program Monitoring System for Benefits Monitoring (PROM-BMP) is finalized and made available to the Contractor.
(e) Other administrative requests required by DCH

(5) Health Information Technology

The Contractor must comply with MDCH performance programs and contract requirements designed to advance provider adoption and meaningful use of certified health information technology (HIT). MDCH is implementing the Medicaid Electronic Health Record (EHR) incentive program pursuant to the final rule on meaningful use of EHRs under the Medicare and Medicaid EHR incentive programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH). Contractors are encouraged to utilize these rules as guidelines when designing and establishing HIT programs and processes.

Contractors must engage in activities that further MDCH's goal that Medicaid eligible professionals and hospitals become Stage I meaningful users. At a minimum, the Contractor should perform the following activities:

- Assist MDCH in statewide efforts to target high volume Medicaid providers that may be eligible for the EHR incentive payments
- Align provider incentives with meaningful use measures
- Promote the EHR Incentive program as part of regular provider communications
- Exchange eligibility and claim information electronically to promote the use of electronic health records

(6) PROM-BMP

Upon availability of PROM-BMP, Contractors are strongly encouraged to utilize the system to identify enrollees who are candidates for the BMP Program. When the PROM becomes available, the Contractor must utilize PROM to submit requests to place enrollees in the BMP. Contractors must also utilize PROM-BMP to designate the restricted provider(s) when the functionality becomes available.

12. Contributions and MI Health Account – Remedies

Section 1.022EE (1) (Remedies) is hereby amended to include the following:

- MI Health Account services and practices including compliance with the CMS approved Operational Protocol for MI Health Accounts

- Healthy Behavior policies and procedures including compliance with the CMS approved Operational Protocol for Healthy Behaviors

13. Enrollment

Section 1.022A (2) (Initial Enrollment) is replaced in its entirety with the following:

The Contractor will accept as enrolled all enrollees appearing on monthly enrollment reports and infants enrolled by virtue of the mother's enrollment status. The Contractor must accept enrollees for enrollment in the order in which they apply without restriction. The Contractor may not discriminate against beneficiaries on the basis of health needs, health status, or payment of cost sharing requirements. The Contractor may not encourage an enrollee to disenroll because of health care needs, a change in health care status, or failure to pay cost sharing. Further, an enrollee's health care utilization patterns or non-payment of cost sharing may not serve as the basis for disenrollment from the Contractor. This provision does not prohibit the Contractor from conducting DCH-approved outreach activities for CSHCS or other State and federal health care programs.

14. Co-payments

Section 1.022F(5) (Copayments) is hereby replaced in its entirety with following:

(5) Co-Payments

The Contractor may require co-payments by enrollees, consistent with State and federal guidelines, Medicaid Policy, waivers obtained by DCH, and other DCH requirements. Co-payments for HMP enrollees must be identical in amounts and applicable services to co-payments for fee-for-service as specified in Medicaid policy. No co-payments will be collected for six months following initial enrollment with a HMP Contractor. Following the initial six month period, the MI Health Account Vendor must collect a monthly co-payment fee equal to the average co-payments for services paid by the Contractor in the previous encounter data reporting quarter; HMP enrollees will not remit co-payments at point of service for services covered under the contract. The MI Health Account Vendor must re-calculate the monthly co-payment amount due every quarter months based upon claims paid in the encounter data reporting quarter and include the co-payments charged and the monthly co-payment amount due on the quarter MI Health Account Statement as specified in 1.022H(5).

The Contractor must not implement co-payments without DCH approval. Enrollees must be informed of co-payments upon enrollment and upon any changes to co-payment requirements. Co-payment requirements must be listed in the member handbook.

No provider may deny services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

15. Healthy Behaviors and Health Risk Assessment

Section 1.022(H) (Enrollee Services) is hereby amended to include a new subsection (6):

(6) Healthy Michigan Plan Enrollee Healthy Behaviors and Health Risk Assessment

As established 107 P.A. 2013, Contractors are required to work with HMP enrollees to assess health risk status and facilitate the adoption of healthy behaviors, specifically regarding:

- Alcohol use
- Substance use disorders
- Tobacco use
- Obesity

- Immunization status

The Contractor must establish, implement and operate healthy behavior incentives and assessments in accordance with this Contract and the CMS approved Operational Protocol for Healthy Behaviors which will be developed in consultation with the Contractor. The Contractor must comply with all requirements in the protocol.

Contractors must ensure that all HMP enrollees have an annual health risk assessment and receive the first health risk assessment during the initial enrollment period with an MHP Contractor. Contractors must utilize a DCH-approved Health Risk Assessment (HRA) protocol. MI Enrolls will conduct the first nine questions of the initial HRA for HMP enrollees via the telephone at the time of enrollment with the Contractor. The HRA results will be transmitted via the Data Exchange Gateway to the Contractor.

HMP enrollees must have an appointment scheduled with a PCP within 60 days of initial enrollment. The Contractor must develop and implement specific policy and procedure regarding enrollee and provider outreach to facilitate scheduling this appointment. The policies and procedures should also address completion of a DCH-approved HRA prior to or during the first appointment during the enrollee outreach if an HRA was not completed at MI Enrolls at the time of enrollment choice. These policies and procedures must be submitted to DCH for review, comment and approval upon request.

Contractors must educate network providers about the initial appointment standards, the HRA process and the required PCP attestations. Contractors must utilize the DCH approved PCP attestation form. The Contractor must establish a mechanism for obtaining the completed HRA, including PCP attestation, from the PCP. The Contractor must store the results of the HRA and the PCP attestation. Per the guidelines outlined in the CMS approved Operational Protocol for Healthy Behaviors, the Contractor must determine if the enrollee is eligible for a reduction in co-payment and/or contributions. The Contractor must also transmit the completed HRA including the PCP attestation to DCH via the 5708 file.

16. Healthy Behaviors and Health Risk Assessment – Incentive Materials
    Section 1.022CC (4) (Marketing and Incentive Materials) is hereby replaced in its entirety with the following:

    All written and oral marketing materials must be approved by DCH prior to use. Upon receipt by DCH of a complete request for approval that proposes allowed marketing practices and locations, DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. The review clock will be tolled while the Contractor revises materials for re-submission.

    All written and oral materials associated with DCH-mandated incentive programs for HMP enrollees must be approved by DCH prior to use. Upon receipt by DCH of a completed request for approval of an incentive program consistent with the mandate, DCH will provide a decision to the Contractor within 15 business days or the Contractor's incentive program will be deemed approved. The review clock will be tolled while the Contractor revises materials for re-submission.

17. Advance Directive

    Section 1.022H (3) (b) (Advance Directives) is hereby amended to include the following:

    ii. Advance directives, including, at a minimum: (1) information about the Contractor's advance directives policy, (2) information regarding the State's advance directives provisions and (3) directions on how to file a complaint with the State concerning noncompliance with the advance directive requirements. Any changes in the State

law must be updated in this written information no later than 90 days following the effective date of the change. In addition, for HMP enrollees: (1) the DCH approved Advance Directive Form with information on how to complete the form and contact information for assistance with form completion, and (2) A postage-paid envelope addressed to the Peace of Mind Registry,

18. Reporting

Section 1.042 (Reporting) is hereby amended to include the following:

(9) Healthy Michigan Plan Reporting
The Contractor must comply with all the reporting requirements specified in the following:

- Operational Protocol for MI Health Accounts
- Operational Protocol for Healthy Behaviors
- CMS Special Terms and Conditions of the 1115 Waiver Approval
- 107 P.A. 2013

19. Excluded Populations
Section 1.022A (Excluded Populations) is hereby amended to include the following bullet# 4 under Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:

- Medicaid eligible persons enrolled under the Healthy Michigan Plan

20. Covered Services
Section 1.022E1 (Covered Services) is hereby amended to include the following:

The covered services provided to HMP enrollees under this Contract include all those listed above and the following additional services:

- Additional preventive services required under the Patient Protection and Affordable Care Act as outline by DCH
- Habilitative services
- Dental Services
- Hearing aids for persons 21 and over

21. Risk Mitigation

Section 1.062C (Risk Mitigation) is hereby replaced in its entirety with the following:

C. Payment Option
Contracts are full-risk. However, the State will implement a risk mitigation strategy for the Healthy Michigan Plan payments as delineated in the rate certification letter from the State's actuary.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 11
to
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
CoventryCares of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MDCH	Greg Rivet	(517) 335-5096	rivetg@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2014
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		September 30, 2014

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$956,318,905.69

Effective immediately, the attached Contract changes for Fiscal Year 2014 are hereby INCORPORATED into this Contract.

All other terms, conditions, specifications, and pricing remain the same.

Per vendor and agency agreement and DTMB Procurement approval.

Contract Changes Fiscal Year 2014
Contract Changes are Effective 10/01/2013

Section A: MDCH Initiated Changes

1. Contract Term

Section 2.001 - Contract Term is hereby replaced in its entirety with the following::

This Contract is for one year beginning 10/1/2013 through 9/30/2014. All outstanding Purchase Orders expire upon termination of the Contract, unless otherwise extended under the Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of the Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2. Transportation

Section 1.022(10) Transportation - is hereby replaced in its entirety with the following:

When necessary, the Contractor must provide non-emergency transportation, including travel expenses, to authorized, covered services. The Contractor must provide, at a minimum, the services outlined in the DHS guidelines (BAM 825) for the provision of non-emergency transportation including the provision of travel expenses, meals, and lodging. The Contractor may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles. However, prior authorization may not be denied based on distance alone; the Contractor must consider burden on the enrollee/enrollee family based on the particular needs of the enrollee and the medical benefit of parent presence during pediatric inpatient stay. The Contractor may also utilize DHS guidelines for the evaluation of a member's request for medical transportation to maximize use of existing community resources; however, Contractors must also consider special transportation needs of enrollees eligible for Children with Special Health Care Services.

Contractor's transportation policy and procedures must include the following provisions:

- Prevention of excessive multi-loading of vehicles such that individuals are required to travel for significantly longer periods of time than is necessary for travel to/from home to place of covered service
- Determination of the most appropriate mode of transportation to meet the enrollee's medical needs, including special transport requirements for enrollees who are medically fragile or enrollees with physically/mentally challenges. Contractors should use the considerations identified in the DHS guidelines (BAM 825).
- Scheduling system must be able to schedule enrollee transportation services in at least three modes:
    - On-going set appointment times for a one month period for standing appointments such as, but not limited to, dialysis, chemotherapy or physical therapy
    - Regularly scheduled appointments; plans may require reasonable advance notice (e.g. 48 – 72 hours) of the need for transportation
    - Urgently scheduled appointments for which enrollee requires transportation on the same day as request or following day
- Method for reimbursing mileage to individuals when it is appropriate for the enrollee to drive or be driven to an urgent care facility or emergency department.
- Description of how Contractor will monitor transportation subcontractors to ensure subcontractor compliance with these provisions

Contractor must submit the Contractor's non-emergency transportation policies, procedures, and utilization information to DCH, upon request, to ensure this requirement is met.

The Contractor must provide medical transportation to receive any service covered by this Contract, including, but not limited to the following:

- Chronic and ongoing treatment

- Prescriptions
- Medical supplies
- Visits for medical care

The transportation benefit does not include transportation to services that are not covered under this Contract such as transportation to Women, Infant, and Children (WIC) services, dental office services, specialized CMHSP services or support, or transportation to substance abuse services.

3. Tobacco Cessation

Section 1.022(F)(20) - Tobacco Cessation Treatment is hereby replaced in its entirety with the following:

The Contractor must provide covered tobacco cessation treatment that includes, at a minimum, the following services:

(a) Intensive tobacco use treatment through a DCH approved telephone quit line
(b) Group and/or individual counseling/coaching for tobacco cessation treatment separate from the 20 outpatient mental health visits
(c) All of the following Over-the counter agents used to promote smoking cessation
    i. Patch
    ii. Inhaler
    iii. Nasal Spray
    iv. Gum or lozenge
(d) At least one prescription of non-nicotine medication used to promote smoking cessation
(e) Combination therapy – counseling/coaching in conjunction with an over-the-counter agent and/or a prescription of non-nicotine medication used to promote smoking cessation.

DCH encourages the Contractor to have no co-payment or prior authorization requirements for tobacco cessation treatment. However, the Contractor may place a reasonable limit on the type and frequency of over-the-counter and prescription agents covered under this benefit. The Contractor may also require prior authorization for prescription drugs. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

4. Health Indicator Incentives

1.022(H)(2) – Enhanced Services is hereby amended to include the following:

The Contractor is encouraged to provide member incentives to encourage adult beneficiaries to get an annual preventive visit that includes the four health screenings recommended as part of the Michigan 4 X 4 plan:

- Body Mass Index (BMI)
- Blood Pressure
- Cholesterol Level
- Blood Glucose Level

The member incentives must meet all requirements for incentives, including but not limited to DCH approval prior to implementation.

Section 1.022(P) – MIS Capacity is hereby replaced in its entirety with the following:

(1) MIS Capability

The Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by DCH. The information system must have the capability for:

(a) Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by DCH through an encounter data system
(b) Collecting data to monitor services provided to enrollees on the measurement of the following key indicators:

- Body Mass Index (BMI)
- Blood Pressure
- Cholesterol Level
- Blood Glucose Level

(c) Supporting provider payments and data reporting between the Contractor and DCH

(d) Controlling, processing, and paying providers for services rendered to Contractor enrollees

(e) Collecting service-specific procedures and diagnosis data, collecting price-specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintaining detailed records of remittances to providers

(f) Supporting all Contractor operations, including, but not limited to, the following:

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

ii. Utilization

iii. Provider enrollment

iv. Third party liability activity

v. Claims payment

vi. Grievance and appeal tracking, including tracking for CSHCS enrollees separately

Section 1.022(Q) – Provider Services (In-Network and Out-of-Network) is hereby amended to include the following:

The Contractor must:

(10) Develop and implement provider incentives to encourage providers to track patient screenings for the 4 key health indicators specified in the Michigan 4 X 4 plan:

- Body Mass Index (BMI)
- Blood Pressure
- Cholesterol Level
- Blood Glucose Level

5. Notification of Availability of Translation Services

Section 1.022(R)(2) – Network Requirements is hereby amended to include the following

(i) Responds to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the Medicaid population. Upon request, Contractor must submit evidence to DCH, that the Contractor notifies provider network that written and spoken language translation services are available to members in any setting (ambulatory, inpatient, and outpatient). Notification, and evidence thereof, must include, but is not limited to, hospital providers, and must be done at least annually.

6. Data Sharing

Section 1.022(W) - Coordination of Care with Public and Community Providers and Organizations is hereby amended to include the following:

(5) Electronic Data Exchange

Contractors must develop and implement a mechanism that allows for the bi-directional exchange of enrollee data between the Contractor and the LHD as well as between the Contractor and the CMS clinics. The Contractor must utilize electronic data exchange to coordinate care with the LHD and with the CMS. The Electronic Data Exchange must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations.

7. Measurement Data

Section 1.022(A)(2) - Initial Enrollment is hereby amended to include the following:

Under the automatic enrollment process, beneficiaries will be automatically assigned based on the Contractor's performance in areas specified by DCH. Individuals in a family unit will be assigned together whenever possible. DCH will automatically assign a larger proportion of beneficiaries to Contractors with a higher performance ranking. The performance ranking will be based on such factors as data from the Healthcare Effectiveness Data and Information Set (HEDIS®) and other data sources , blood lead scores, and the ability of the Contractor to consistently meet the quality and administrative performance monitoring standards. The capacity of the Contractor to accept new enrollees and to provide accessibility for the enrollees also will be taken into consideration in automatic beneficiary enrollment. DCH has the sole authority for determining the methodology and criteria to be used for automatic enrollment.

Section 1.022(Z)(1) - Quality Assessment and Performance Improvement Program (QAPI) is hereby amended to include the following:

xiv. Ensure the equitable distribution of health care services to their entire population, including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities.

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

Section 1.022(Z) - Quality Assessment and Performance Improvement Program is hereby amended to include the following:

(7) Medicaid Health Equity Project

Contractor will fully and completely participate in the Medicaid Health Equity Project and report all required information to DCH within the specified timeline.

Section 1.042 – Reports is hereby amended to include the following:

(9) HEDIS Member-Level Data

Contractor will submit member-level HEDIS data as specified via a submission process to be determined by DCH in consultation with the Contractor.

(10) Provider Race/Ethnicity Reporting

Contractor will work with providers and DCH to collect and report the race/ethnicity of their contracted providers. Contractor will report the race/ethnicity of contracted providers to DCH within the specified timeline.

(11) Other Data Sources

DCH may develop other data sources and/or measures during the course of the contract term. DCH must work with the Contractor to develop data formats and mechanisms for data submission. The Contractor must work with DCH to provide data in the format and timeline specified by DCH.

8. Reporting

Revise Section 1.042(A)(2)(c) - EPSDT Information is hereby replaced in its entirety with the following:

c. EPSDT information: The Contractor must provide the following:
   i. List and brief description of member incentives offered to increase member utilization of EPSDT services

ii. List and brief description of provider incentives offered to increase provider monitoring of / providing EPSDT services

Section B: Medicaid Health Plan (MHP) Initiated Changes:

9. Beneficiary Monitoring Program

Section 1.022(H)(4) - Benefits Monitoring Program is hereby amended to include the following:

> DCH will review and approve remedies and sanctions the Contractor develops for managing enrollees in the BMP program. All remedies and sanctions must be allowed by Medicaid policy and State and Federal law. Upon review, DCH will provide the Contractor with written notice of approval.

10. FQHC

Section 1.022(F)(4) - Federally Qualified Health Centers (FQHCs) is hereby amended as follows:

> If a Contractor has an FQHC in its provider network in the county and allows members to receive medically necessary service, including behavioral health services provided as part of the 20 outpatient mental health visits, from the FQHC, the Contractor has fulfilled its responsibility to provide FQHC services and does not need to allow enrollees to access FQHC services out-of-network.

11. Sanctioned and Debarred Providers

Revise 1.022(O)(3) – Prohibited Affiliations with Individuals Debarred by Federal Agencies is hereby amended to include the following:

> Upon confirmation that a network provider is enrolled or registered in the DCH MMIS provider enrollment system, the Contractor may utilize reports from DCH. The DCH reports, pursuant to the DCH monthly screening process, will notify Contractors and others when a registered or enrolled provider is sanctioned or otherwise debarred from participation in Medicaid. Upon request, the Contractor must provide evidence of review and use of the DCH sanctioned provider reports.

12. Definition of Potential Enrollee

Revise Definition and Terms to include the following:

> Potential enrollee means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Contractor or other Managed Care Organization.

13. Release of Report Data

Section 1.042B– Release of Report Data is hereby replaced in its entirety with the following:

B. Release of Report Data

The Contractor must obtain DCH's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its enrollees other than as required by this Contract, statute or regulations. The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract. The Contractor will not use the State's data for any purpose other than providing the Services to enrollees covered by the Contractor under any Contract or Program, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data. Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services to enrollees covered by the Contractor

under any Contract or Program and must disclose the information only to its employees on a strict need-to-know basis. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

Section C: Appendices and Attachments:

14. Appendices

Appendix 2, 3 and 4 are hereby replaced in their entirety with the attached versions of the appendices

15. Attachments

Attachment B is hereby amended to include the following:

Fiscal Year 2014

The State of Michigan Fiscal Year 2014 Managed Care Rates, effective October 1, 2013 through September 30, 2014, will be paid within the certified, actuarially sound rate range. If rates require recertification during the contract year, a contract amendment will be issued. The rates for Fiscal Year 2014 were distributed via e-mail on September 13, 2013 and are incorporated herein by reference.

Health Plan Name	FY 14 Performance Bonus Template	*70%*	NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2014 HEDIS	**2014 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds- Ages 5-11		0	0.0%	0.0%	0.0%
Adult BMI		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Other					
Children BMI		0	0.0%	0.0%	0.0%
Childhood - Combo 3		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2014 HEDIS	**2014 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%
7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	**Last CAHPS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50.00%**	**75.00%**	**90%**
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%
Advising Smokers and Tobacco Users to Quit		0	0.0%	0.0%	0.0%

Smoking Measures	Score	50% (1 point); 75% (2 points); 90% (3 points)	50%	75%	90%
Tobacco Cessation Strategies		0	0.0%	0.0%	0.0%
Medical Assistance with Smoking and Tobacco Use		0	0.0%	0.0%	0.0%

Accreditation Status - 2014	Accredited or Conditional as of 12/31/13 (7 pts)	NCQA New Plan or URAC Provisional Accreditation as of 12/31/13 (8.5 points)	Excellent/ Commendable or Full Accreditation as of 12/31/13 (10 Pts)
Org Name (Date of visit)			
Total Member Months of Enrollment by Age and Sex - HEDIS 2014	**0**		

Point Summary	Possible Points	Health Plan Points
Clinical Measures (54.84%)	68	0.0
Access to Care (19.35%)	24	0.0
Survey Measures (CAHPS) (17.74%)	22	0.0
Accreditation Status (8.06%)	10	0.0
Performance Bonus Total Score	**124**	**0.0**

CAHPS Survey Measures

based on 2013 NCQA Quality Compass Medicaid Percentiles

Appendix 2

DCH Financial Monitoring Standards

Reporting Period	Monitoring Indicator	Threshold	DCH Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	DCH written notification	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance
Quarterly Financial	Net Worth	Negative Net Worth	DCH written notification Freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Medical Loss Ratio	Below minimum of 83%	DCH written notification Freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	150-200% RBC	DCH written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	100-149% RBC	DCH written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

Appendix 3
2014 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

All reports must be **shared** electronically via the **DCH File Transfer Application**.

Exceptions are the encounter data and provider file which are submitted electronically via the DEG.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Consolidated Annual Report	3/1/14	1/1/13 – 12/31/13	Contract 1.042A(2)
• Health Plan Profile (MSA 126 (01/06)) NOTE: **Follow instructions carefully and include all required attachments.** • Financial (NAIC, all reports required by OFIR, and Statement of Actuarial Opinion are due with the annual report on 3/1/14). *NOTE: The Management Discussion and Analysis is due 4/1/14 and the Audited Financial Statements are due 6/1/14.* • Health Plan Data Certification Form (MSA 2012 (02/08)). • Litigation (limited to litigation directly naming health plan, MSA 129 (09/99)) • Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms) • Medicaid Certificate of Coverage • Medicaid Member Handbook • EPSDT Requirements: o **Incentives:** List, with brief description, member incentives offered to increase member utilization of EPSDT services; List, with brief description, provider incentives offered to increase monitoring of/providing EPSDT services			
Management Discussion and Analysis for Annual Financial	4/1/14	1/1/13 – 12/31/13	Contract 1.042 A(2)
Audited Financial Statements	6/1/14	1/1/13 – 12/31/13	NAIC, OFIR
QIP Annual Evaluation and Work Plan	8/1/14	Current, Approved 2013 Evaluation, 2014 Work Plan	Electronic Format; Contract 1.022 Z(1-4)
HEDIS® Compliance Audit – Final Audit Report	8/1/14	1/1/13 – 12/31/13	NCQA formatted, electronic copy
HEDIS® IDSS	7/1/14	1/1/13 – 12/31/13	NCQA formatted, electronic copy
• Auditor-locked Excel format Audit Review Table (ART) • Excel Downloads: Comma Separated Values (CSV) Workbook • Excel Downloads: Data-filled Workbook (measure level detail file), and • Copy of MHP's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter			
Quarterly Submissions			

Report Reference	Due Date	Period Covered	Instructions/Format
Grievance/Appeal	1/30/14 4/30/14 7/30/14 10/30/14	10/1/13 – 12/31/13 1/1/14 – 3/31/14 4/1/14 – 6/30/14 7/1/14 – 9/30/14	MSA 131 (11/11), Grievance & Appeal Report
Financial	5/15/14 8/15/14 11/15/14	1/1/14 – 3/31/14 4/1/14 – 6/30/14 7/1/14 – 9/30/14	NAIC and OFIR
Third Party Collection	5/15/14 8/15/14 11/15/14	1/1/14 – 3/31/14 4/1/14 – 6/30/14 7/1/14 – 9/30/14	Report on separate sheet and send with NAIC
Monthly Submissions			
Claims Processing	30 days after end of the month NOT last day of month	• Data covers previous month • i.e., data for 2/14 due by 3/30/14	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/14 due by 2/15/14	837 Format NCPDP Format
Provider Files (4275)	Thursday before the last Saturday of each month	• Submit all providers contracted with the plan on the date of submission • Submit two files, one utilizing the MA-MC provider voluntary ID and one utilizing the CSHCS-MC provider voluntary ID	4275 layout and file edits distributed by DCH

MEDICAID MANAGED CARE
Medicaid Health Plans

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans. DCH will finalize and distribute the performance monitoring standards to the Contracting Health Plans prior to October 1 of each year.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE)**.

Appendix 5
2014 DCH P4P Bonus
Benefits Monitoring Program

Category	Description	Criteria/Deliverables
Benefits Monitoring Program (BMP) Innovation	The Medicaid program is required to conduct surveillance and benefits utilization review to ensure that appropriate services are provided to program beneficiaries. The Michigan monitoring program is called Benefits Monitoring Program (BMP)	The MHP must provide information that describe and support efforts to conduct surveillance and benefits utilization review.
1. Placement of candidates	1. The placement of a beneficiary into the BMP (a monitoring program) must be based on one or more defined criteria; such as: a. Fraud b. Misutilization of ER, Rx, transportation or physician services **c.** other	1. **Due October 1, 2013** – MHP will have a *DCH approved* Policy/Procedures that describe its Monitoring Program and coordination with the DCH BMP policy. (**MHPs must submit their draft P/P for DCH approval by 7/1/2013**). a. Placement criteria b. Restrictions/Exemptions c. Notice/communication to member d. Hearings/Appeals e. Monitoring and Review
2. Criteria for PCP assignment and provider lock-in	2. The BMP authorized providers assigned may include a specific PCP, pharmacy, outpatient hospital, specialist or group practice. Provider must be authorized through BMP to prescribe drugs subject to abuse. Authorized PCP must utilize appropriate form to refer to other specialist providers and notify DCH when beneficiary is discharged from their practice.	2. **Due April 1, 2014 –** MHP provide: a. Criteria for PCP assignment b. Mechanism of provider lock-in c. Provider referral process d. Notice of discharge of member
3. Care management models	3. MHPs must work with the assigned providers to collaborate on case management, coordination of all prescribed drugs, specialty care and ancillary services.	3. **Due July 1, 2014** – MHP to: Develop and/or incorporate BMP members into existing care management model specific to this population

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

September 13, 2013

CHANGE NOTICE NO. 10
to
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
CoventryCares of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MDCH	Greg Rivet	(517) 335-5096	rivetg@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS	
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	1 Year	September 30, 2014

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$196,877,624.00	$956,318,905.69

Effective immediately, the attached Contract changes are hereby INCORPORATED into this Contract. In addition, this Contract is hereby INCREASED by $196,877,624.00 and is utilizing the first option year. The new Contract end date is September 30, 2014.

All other terms, conditions, specifications, and pricing remain the same.

Per vendor and agency agreement, DTMB Procurement approval, and the approval of the State Administrative Board dated September 13, 2013.

Contract Changes April 2013
Contract Changes are Effective 4/01/2013

16. Contract Objectives

Section 1.021 - In Scope - A. General Objectives, is hereby replaced in its entirety with the following:

- Access to primary and preventive care
- Establishment of a "medical home" and the coordination of all necessary health care services
- Provision of high quality medical care that provides continuity of care and is appropriate for the individual
- Operation of a health care delivery system that enables Michigan to control and predict the cost of medical care for the Medicaid population
- Market-based health care to stimulate healthy competition that ultimately benefits the enrollees and the State
- Emphasis on value within the Contractor's performance and utilizing only Contractors that can demonstrate value added
- Evidence-based medicine to ensure Contractors are providing quality care with efficiency and cost-effectiveness
- Ensuring transparency of cost and quality information to assist Contractors and the State in increasing quality while decreasing costs
- Continue the emphasis on primary care transformation and the movement to primary care medical homes
- Emphasize prevention of chronic disease and focus on care coordination to improve quality of care and contain costs
- Ensure innovative projects are encouraged and allowing Contractors to propose innovative projects focused on better care for the enrollees while maintaining or decreasing costs
- Reward personal responsibility by encouraging Contractors to reward enrollees who make healthy choices that help the Contractor and the State contain cost of Medicaid care

17. EPSDT/Autism

Paragraph 2 & 3 of Section 1.022(F) (9) – Well Child Care/Early and Periodic Screening, Diagnosis and Treatment Program, is hereby replaced in its entirety with the following:

As specified in federal regulations, the screening component includes a general health screening most commonly known as a periodic Well Child/EPSDT examination. The required Well Child/EPSDT screening guidelines, based on the American Academy of Pediatrics' (AAP) recommendations for preventive pediatric health care, include:

- Health and developmental history
- Height and weight measurements and age appropriate head circumference
- Blood pressure for children 3 and over
- Age appropriate unclothed physical examination
- Age appropriate screening, testing and vaccinations
- Immunization review and administration
- Blood lead testing for children under 6 years of age; children must be tested by 12 months of age and 24 months of age
- Developmental screening
- Autism screening
- Developmental surveillance
- Psychosocial/behavioral assessment
- Alcohol and drug use assessment
- Nutritional assessment
- Hearing, vision and dental assessments
- Health education including anticipatory guidance
- Interpretive conference and appropriate counseling for parents or guardians

Additionally, developmental/behavioral, hearing, and vision screening and testing must be performed in accordance with the Medicaid Policy and periodicity schedule. Laboratory services for hematocrit, hemoglobin, urinalysis, hereditary/metabolic, or other needed testing as determined by the physician must be provided.

18. Beneficiary Monitoring Program

Section 1.022(B)(1) - Special Disenrollments, is hereby replaced in its entirety with the following:

The Contractor may initiate special disenrollment requests to DCH if the enrollee acts in a violent or threatening manner:

Violent/ threatening situations involve physical acts of violence; physical or verbal threats of violence made against Contractor providers, staff, or the public at Contractor locations; or stalking situations.

A Contractor may not request special disenrollment based on the physical or mental health status of the enrollee. If the enrollee's physical or mental health is a factor in the actions inconsistent with plan membership, the Contractor must assist the enrollee in correcting the problem, which includes making the appropriate physical and mental health referrals. .

The Contractor must make contact with law enforcement, when appropriate, before seeking disenrollment of enrollees who exhibit violent or threatening behavior. DCH reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment. The effective disenrollment date shall be within 60 days from the date DCH received the complete request from the Contractor that contains all information necessary for DCH to render a decision. If the beneficiary exercises their right of appeal, the effective disenrollment date shall be no later than 30 days following resolution of the appeal.

Section 1.022(H) - Enrollee Services, is hereby amended to include the following:

(4). Beneficiary Monitoring Program

The Contractor must utilize a systematic method for the identification of individuals who meet the criteria for the Beneficiary Monitoring Program (BMP) under Medicaid policy. DCH strongly encourages Contractors to utilize the BMP-PROM system for the identification of BMP candidates. Upon identification, the Contractor must notify the enrollee that she/he will be placed in the BMP and provide an effective date (no less than 12 days after notification). The Contractor must also participate in DCH Fair Hearings that result if the enrollee appeals any adverse action while the beneficiary is in BMP (e.g. provider restriction).

Upon placement in the BMP, the Contractor must provide education to the enrollee on the correct utilization of services. The Contractor should assist the enrollee in removing barriers to the enrollee's correct utilization of services and make the appropriate referrals to mental health and substance abuse providers when appropriate. The Contractor must systematically monitor the enrollee's utilization of services to determine whether the placement in BMP and education have modified the enrollee's behavior. The Contractor should establish timelines consistent with Medicaid policy for the review of each enrollee in BMP to determine if the enrollee has met goals and guidelines and may be removed from BMP.

Section 1.022(P)(4) **-** Automated Contact Tracking System, is hereby replaced in its entirety with the following:

The Contractor is required to utilize the Department's Automated Contact Tracking System to submit the following requests:

(a) Disenrollment requests for out of area members who still appear in the wrong county on the Contractor's enrollment file
(b) Request for newborn enrollment for out of state births or births for which DCH does not notify the Contractor of the newborn's enrollment within two months of the birth
(c) Maternity Case Rate (MCR) Invoice Generation request for births for which the Contractor has not received an MCR payment within three months of the birth

(d) Requests to place enrollees in the Beneficiary Monitoring Program; this requirement will be phased out as the new Program Monitoring System for Beneficiary Monitoring (PROM-BMP) is finalized and made available to the Contractor.
(e) Other administrative requests required by DCH

Section 1.022(P) – Management Information System, is hereby amended to include the following:

(6) PROM-BMP

Upon availability of PROM-BMP, Contractors are strongly encouraged to utilize the system to identify enrollees who are candidates for the BMP Program. When the PROM becomes available, the Contractor must utilize PROM to submit requests to place enrollees in the BMP. Contractors must also utilize PROM-BMP to designate the restricted provider(s) when the functionality becomes available.

19. Enrollee Education

Paragraph 2 of 1.022(H)(2) – Enrollee Education, is hereby replaced in its entirety with the following:

The Contractor may provide health education to its enrollees, including health screens, in a provider office. This education must meet all of the following criteria:

a. Incentive must be delivered in separate private room
b. No advertisement of the event may be present or distributed in the provider office
c. Only health plan enrollees may participate

20. QI Director Requirements

Subsection 1.031(C)(3)Quality Improvement and Utilization Director, is hereby replaced in its entirety with the following:

(3) Quality Improvement and Utilization Director

The Contractor must provide a full-time Quality Improvement and Utilization Director who possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be any of the following:

- Michigan licensed physician
- Michigan licensed registered nurse
- Certified professional in health care quality
- Other licensed clinician as approved by DCH
- Other professional possessing appropriate credentials as approved by DCH

The Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.

21. ACA Primary Rate Increase

Section1.022(Y) Payment to Providers, is hereby amended to include the following:

(9) ACA Primary Rate Increase

Each quarter, DCH will provide the Contractor with a list of network providers eligible for primary rate increase dollars. In addition to the list of providers, DCH will provide a specific dollar amount (payment) that the Contractor must distribute to each provider. The Contractor must distribute all payments as specified by DCH. The Contractor's Chief Financial Officer, or designee, must attest that the Contractor made all specified payments within 14 days of receipt of the information from DCH.

22. PCP Submission File

Section 1.022(R)(3) - Provider Network File and PCP Submission File, is hereby replaced in its entirety with the following:

> The Contractor must participate in the DCH file process for obtaining Contractor PCP data for the DCH eligibility verification system. The Contractor must submit PCP changes, deletions, and additions at least once per month or weekly as required by 1.022(H). Additionally, the Contractor must be able to submit a **complete file** showing all PCP assignments when requested by DCH.

23. Revised Appendix 5

Appendix 5 is hereby replaced in its entirety with the attached Appendix 5.

24. Revised Attachment B

Attachment B is hereby replaced in its entirety with the following:

Contractor's Awarded Rates

The State of Michigan Fiscal Year 2013 Managed Care Rates, effective October 1, 2012 through September 30, 2013, will be paid within the certified, actuarially sound rate range. If rates require recertification during the contract year, a contract amendment will be issued.

Enrollment of CSHCS beneficiaries in Medicaid Health Plans from October 2012 to March 2013 differed from the projected enrollment used in the original rate certification. Rates have been recertified to reflect these changes retroactively to October 1, 2012. The impact of this change resulted in a rate increase.

Due to the transition of CSHCS beneficiaries and the addition of several services for other populations, base rates were recertified for the period of April 1, 2013 through September 30, 2013. The impact of this change resulted in a rate increase.

Health Plan
2013 CSHCS Focus Study

Competency	Area of Focus	Points Possible	Points Awarded
1	**Access to Care** – Evidence of access standards for CSHCS population and processes to evaluate compliance with those standards	5	
2	**Access to Care –** Evidence of analyzing and determining adequacy of network: PCP with experience with children complex health conditions, member assignment to attested PCP, specialty network and hospital contracts, expanded access, and 24/7 availability	5	
3	**Access to Care –** Review executed contracts or effort to network with pediatric subspecialist, children's hospitals, pediatric specialty care hospitals and pediatric regional centers	5	
4	**Access to Care –** Evidence of implemented PA process with pediatric subspecialists	5	
5	**Access to Care –** Evidence of implemented PA process with specialty DME	5	
6	**IT Systems –** Generate measures of utilization, access and quality of care, demonstrate tracking ability, and review data sharing activities **Quality of Care –** Demonstrate that measures applied to the pediatric population as a whole are being applied to the CSHCS population. Data for this subpopulation should be available for specific analysis to see if the basic HEDIS measures are being met for the children/youth Evidence of established clinical practice guidelines specific to CSHCS, such as, diabetes (type 1), asthma and sickle cell disease, etc.	5	
7	**Member Rights (Grievance & Appeals) –** Evidence of process to analyze and report grievances and appeals, rate of grievance and appeals for CSHCS enrollees, and rate of appeals for CSHCS enrollees specifically related to prior authorization	5	

8	**Family Centered Medical Home –** Evidence of member/family participation in interdisciplinary care team and care planning process	5	

2013 Performance Bonus
Focus Study Point Allocation

Access to Care (CM)

1. Evidence of access standards for CSHCS population and processes to evaluate compliance with those standards **(FPP).** **5 total pts**

- ☐ CSHCS member service telephone line with personnel trained to work with this population (Family center parent partner will conduct call to customer service line to evaluate dedicated CSHCS member service telephone line or that calls are routed to personnel trained to work with population). *2.5 pts*
- ☐ CSHCS web portal (Family center parent partner will conduct review of web portal for CSHCS information). *2.5 pts*

2. Evidence of analyzing and determining adequacy of network (Staff will check PCP attestation and check member assignment to these PCPs). **5 total pts**

- ☐ PCP with experience with children complex health conditions *1 pt*
- ☐ Member assignment to attested PCP *1 pt*
- ☐ Specialty network and hospital contracts *1 pt*
- ☐ Expanded access *1 pt*
- ☐ 24/7 availability *1 pt*

3. Review executed contracts or effort to network with pediatric subspecialist, children's hospitals, pediatric specialty care hospitals and pediatric regional centers. **5 total pts**

4. Evidence of implemented PA process - pediatric subspecialists. **5 total pts**

5. Evidence of implemented PA process - specialty DME. **5 total pts**

IT Systems (QA)

6. **5 total pts**

A. IT Systems *2 pts.*

- ☐ generate measures of utilization, access and quality of care
- ☐ demonstrate tracking ability

☐ review data sharing activities

Quality of Care (QA)

B. Demonstrate that measures applied to the pediatric population as a whole are being applied to the CSHCS population. Data for this subpopulation should be available for specific analysis to see if the basic HEDIS measures are being met for the children/youth. *2 pts.*

C. Evidence of established clinical practice guidelines specific to CSHCS, such as, diabetes (type 1), asthma and sickle cell disease, etc. *1 pts.*

Member Rights (Grievance & Appeals) (CM)

7. Member Rights (Grievance & Appeals) **5 total pts.**

☐ Evidence of process to analyze and report grievances and appeals *3 pts*

☐ review grievance & appeals reports and logs

☐ Rate of grievance and appeals for CSHCS enrollees *1 pt*

☐ Rate of appeals for CSHCS enrollees specifically related to prior authorization *1 pt*

8. Evidence of member/family participation in interdisciplinary care team and care planning process. **5 total pts**

Health Plan Name	FY 13 Performance Bonus Template		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2013 HEDIS	**2012 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds- Ages 5-11		0	0.0%	0.0%	0.0%
Adult BMI		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Other					
Children BMI		0	0.0%	0.0%	0.0%
Childhood - Combo 3		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2013 HEDIS	**2013 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%

7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	**Last CAHPS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%****	**75%****	**90%****
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%
Advising Smokers and Tobacco Users to Quit		0	0.0%	0.0%	0.0%
Smoking Measures	**Score**	**50% (1 point); 75% (2 points); 90% (3 points)**	**50%**	**75%**	**90%**
Tobacco Cessation Strategies		0	0.0%	0.0%	0.0%
Medical Assistance with Smoking and Tobacco use		0	0.0%	0.0%	0.0%

Accreditation Status - 2013	**Accredited or Conditional as of 12/31/12 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/12 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/12 (10 Pts)**
Org Name (Date of visit)			
Total Member Months of Enrollment by Age and Sex - HEDIS 2013	**0**		

Point Summary	**Possible Points**	**Health Plan Points**	**DCH Focus (Total 40 Pt.)**	**Score**	**Incentive Points**
Clinical Measures (42.0%)	68	0.0	**CSHCS**	0.0%	0.0
Access to Care (15.0%)	24	0.0			
Survey Measures (CAHPS) (13.0%)	22	0.0	Total Points		
Accreditation Status (6.0%)	10	0.0			
Focus Study Requirements (24.0%)	40	0.0	CAHPS Survey Measures		

Performance Bonus Total Score	**164**	**0.0**	**** based on 2012 NCQA Quality Compass Medicaid Percentiles.**

Appendix 5
2013 DCH P4P Bonus
Healthcare for a Diverse Membership

Category	Description	Criteria/Deliverables
1. Race/Ethnicity and preferred language data collection reporting	1. MHP fully and accurately reports the following on the HEDIS IDSS: a. Race/Ethnicity Diversity of Membership (RDM) b. Language Diversity of Membership (LDM)	1. Complete an accurate IDSS for the appropriate measures submitted by 7/01/2013
2. Provider Network	2. MHP collects and reports on race/ethnicity/language (R/E/L) proficiency for network providers.	2. -***If the MHP currently does this***, <u>R/E breakout reports by specialty submitted to DCH by 8/15/2013 (Use the template provided)</u> -***If not,*** explain why not and describe what avenues you will pursue to assess your capacity to do so. (This could include analyzing your current provider credentialing system and working with DCH efforts to collect this information in the CHAMPS system)
	a. MHP publishes practitioner language information in the provider directory for all Primary Care Providers and Specialists (reference: 42CFR438(10)e(2)(i))	a. Submit a copy of provider directory to DCH along with the Consolidated Annual Report by 3/1/2013
	b. MHP notifies network providers (incl. hospitals) at least annually, that written and spoken language services are available to members in any setting (ambulatory, inpatient, outpatient). (Based on Section H of the current MHP contract, Enrollee Services)	b. Submit documentation that such notification was provided. (e.g. copy of a letter, screenshot from online newsletter)
	c. MHP collects and reports <u>to the extent possible on the *number of members and/or number of requests* for language translation/interpretation services for the 6 month period 2/1/2013-7/30/2013, as well as the number of actual services provided.</u>	c. Submit report to DCH by 8/15/2013
3. Health Equity	3. MHP submits HEDIS data broken down by R/E to DCH for specified measures	3. Submit completed templates to DCH 8/15/2013

Appendix 5
2013 Bonus Measures Template
DCH Focus - CSHCS

Category	Description	Criteria/Deliverables
Integration of Children's Special Healthcare Services (CSHCS) eligible into MHPs **40 points**	MDCH established a set of core competencies to determine health plan readiness and competence to receive CSHCS eligible children into their plan. MHPs provided documentation regarding plans to accommodate this population. An evidence-based review of the MHPs proposed plan implementation will be conducted through the compliance review process by DCH staff and the Office of Medical Affairs.	The MHP provides evidence and real-time demonstration that the proposed processes/procedures, and coordination are in place for the enrollment and transition of the CSHCS population into the health plan in the following categories: 1. Access to Care (related competencies #1, 2, 3, 4, 5, and 9) 2. IT Systems (related competencies #1, 2, 5, 6, 7 and 9) 3. Member Rights (related competencies #4, 5, 7, 8 and 9) 4. Family Centered Medical Home (related competencies #2, and 8) 5. Quality of Care (related competencies #6, 8, and 9) • DCH will obtain this information through the FY13 compliance review Focus Study. • Proposed timeframe for this review process will occur between March and **June** of 2013.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 9
to
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
CoventryCares of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MDCH	Greg Rivet	(517) 335-5096	rivetg@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$759,441,281.69

Effective October 1, 2012, the attached Contract changes for Fiscal Year 2013 are hereby INCORPORATED into this Contract.

All other terms, conditions, specifications, and pricing remain the same.

Per vendor and agency agreement and DTMB Procurement approval.

Contract Changes for Fiscal Year 2013
Contract Changes are Effective 10/01/2012

Section A: CSHCS Eligibility and Enrollment

1. Revise Section 1.022 (B) (2) CSHCS Eligibility and Enrollment to read as follows:

The Contractor must follow DCH procedures for the determination and re-determination of CSHCS medical eligibility. DCH reserves the right to require additional information from the Contractor to determine the enrollee's eligibility for CSHCS. The effective date of enrollment in the CSHCS-MC benefit plan is either (1) the first of the month of the child's admission to a facility during which the eligible condition was identified or (2) if the child was not admitted to a facility when the eligible condition was identified, the first of the month that eligible condition was identified and services for the condition were provided.

The Contractor or hospital must submit a complete Medical Eligibility Referral Form (MERF) containing all necessary signatures and ***all*** information required by DCH to determine medical eligibility to DCH within 30 calendar days of admission or Contractor's receipt of notification of the eligible condition. If complete medical documentation that meets the guidelines specified by DCH is not available within the 30-day timeframe, the health plan must submit the MERF and all required medical documentation within 10 calendar days after the information becomes available. The Contractor must notify the enrollee when submitting the MERF to DCH.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

2. Revise Section 1.022 (F) to add new section (21) **Special Coverage Provisions** to read as follows:

(21)CSHCS Enrollees

Special conditions apply to enrollees in the Contractor's health plan who are enrolled in CSHCS. The Contractor should allow CSHCS enrollees to remain with primary and specialty care providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established primary and specialty care providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees; if the primary and specialty care provider does not wish to join the Contractor's network, the Contractor should work with the non-contracted provider on care coordination, prior authorization and medical management. CSHCS enrollees may be brought into network through transition to an appropriate network provider upon consultation and arrangement with the family and the care team. Additionally, if a non-contracted provider declines the Contractor's offer to participate in the plans network and refuses to coordinate with the Contractor's case management team on prior authorization and medical management, the Contractor may move the CSHCS enrollee to a network provider. In the event that the Contractor does not have a contract with the provider, all claims should be paid at the Medicaid FFS rate.

In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, Contractors must accept prior authorizations in place when the CSHCS enrollee is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractors must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization. Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services.

Additionally, Contractors must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment for the custom-fitted durable medical equipment.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

3. Revise Section 1.022 (F)(7) to include CSHCS specific carved-out drugs to the list of medications for which the MHPs are not responsible. Specifically, revise 1.022 (F)(7) to read as follows:

The Contractor may have a prescription drug management program that includes a drug formulary. DCH may review the Contractor's formularies regularly, particularly if enrollee complaints regarding access have been filed regarding the formulary. The Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug that is covered under the Medicaid Pharmaceutical Product List (MPPL).

Drug coverages must include over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin, as covered by the Medicaid FFS program. Condoms must also be made available to all eligible enrollees.

(a) Pharmacy Carve Out
The Contractor is not responsible for drugs in the categories listed on the Medicaid Health Plan carve out list found at https://michigan.fhsc.com/Providers/DrugInfo.asp. The carve out list includes drugs in the following categories:

- anti-psychotic classes and the psychotropic
- drugs in the anti-retroviral classes, including protease inhibitors and reverse transcriptase inhibitors
- substance abuse treatment drugs ; and
- drugs to treat coagulopathies such as hemophilia and orphan drugs which treat rare metabolic conditions

These medications are reimbursed by DCH's pharmacy third party administrator (TPA) through a point-of-service reimbursement system.

The Contractor is still responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for enrollees but may limit access to contracted lab and x-ray providers.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

4. Revise Section 1.022 (H)(2) by adding the following language at the end of the current section:

The Contractor is encouraged to provide specially targeted outreach and education to CSHCS enrollees. The Contractor should provide specific information to CSHCS on navigating the managed care system as well as detailed information on Contractor member services available to assist the enrollee. The Contractor must designate special member services staff to assist CSHCS enrollees and provide these member services staff with additional training and education needed to accommodate the special needs of CSHCS enrollees. CSHCS enrollees and family should be able to access the specially trained member services staff directly.

The Contractor must establish and maintain education and outreach on the Contractor's web site specifically directed to CSHCS enrollees. CSHCS enrollees and families should be able to utilize the web site to obtain information relevant to the special needs of these enrollees. The web site should also allow a mechanism for CSHCS enrollees and family to contact specially trained staff to assist them with access to services and CSHCS enrollee-specific questions.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

5. Revise Section 1.022 (I)(2)(d) to read as follows:

(2)Grievance and Appeal Procedure Requirements

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

. . .

(d) Ensure that the individuals who make decisions on grievances and appeals are individuals who were:

i. Not involved in any previous level of review or decision-making and

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

6. Also, revise Section 1.022(P)(1)(e) to read as follows:

The Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by DCH. The information system must have the capability for:

. . .

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

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

ii. Utilization

iii. Provider enrollment

iv. Third party liability activity

v. Claims payment

vi. Grievance and appeal tracking, including tracking for CSHCS enrollees separately

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

7. Revise first paragraph of 1.022(R) to read as follows:

The Contractor must maintain a network of qualified providers in sufficient numbers and locations within the counties in the service area, including counties contiguous to the Contractor's service area, to provide required access to covered services. The Contractors network must include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees. The Contractor must also provide or arrange accessible care 24 hours per day, 7 days per week to the enrolled population. The Contractor is solely responsible for arranging and administering covered services to enrollees. Covered services must be medically necessary and administered, or arranged for, by a designated PCP. The Contractor must demonstrate that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of all enrollees within each enrollment area. The delivery system (in- and out-of-network) must include sufficient numbers of providers with the training, experience, and specialization to furnish the covered services listed in **Sections 1.022(E) and 1.022(F)** of this Contract to all enrollees.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

8. Revise the second paragraph of Section 1.022(R)(1), the third paragraph of Section 1.022(S)(1) and Section 1.022(S)(3) add a new Section 1.022(S)(4) to read, respectively, as follows:

Enrollees must be provided with an opportunity to select their PCP. CSHCS enrollees must be allowed to remain with the PCP with whom these enrollees have an established relationship at the time of enrollment in the health plan. Contractors are encouraged to seek contracts with PCPs with established relationships with CSHCS enrollees. CSHCS enrollees may be transitioned to an in-network PCP upon consultation with the family and the care team.

If the enrollee does not choose a PCP at the time of enrollment, it is the Contractor's responsibility to assign a PCP within one month of the effective date of enrollment. For CSHCS enrollees, the Contractor must assign a CSHCS-attested PCP. The Contractor must make all efforts to honor the enrollee's choice of PCP. If the Contractor cannot honor the enrollee's choice of the PCP, the Contractor must contact the enrollee to allow the enrollee to either make a choice of an alternative PCP or to disenroll (in counties not covered by the rural area exception). The Contractor must notify all enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.

(1)PCP Choice

The Contractor must allow a physician specialist to serve as a PCP when the enrollee's medical condition warrants management by a physician specialist. This may be necessary for those enrollees with conditions such as diabetes, end-stage renal disease, HIV/AIDS, or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the enrollee. If the enrollee disagrees with the Contractor's decision, the enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file a Fair Hearing Request with DCH. Prior to assigning a specialist as PCP for a CSHCS enrollee, the Contractor must ensure that the specialist's office can adequately provide all necessary primary care services.

(3)PCP Availability

The Contractor must assign a PCP who is within 30 miles or 30 minutes travel time to the enrollee's home, unless the enrollee chooses otherwise. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within 30 miles or 30 minutes travel time. The Contractor will take the availability of handicap accessible public transportation into consideration when making PCP assignments.

The Contractor must allow a CSHCS enrollee to choose a network PCP that is more than 30 minutes, 30 miles from the enrollee's residence under either or both of the following conditions:

- The CSHCS enrollee has an established relationship with the PCP at the time of enrollment in the health plan
- Upon consultation with the family, the selected PCP is the most appropriate PCP for the CSHCS enrollee

If either or both of the above conditions are met, Contractors must provide transportation to PCP services more than 30 minutes, 30 miles from the enrollee's residence. If neither of the above conditions is met and the enrollee still chooses a PCP that is more than 30 minutes or 30 miles from the enrollee's residence, the Contractor is not responsible for transportation to PCP services.

(4)CSHCS PCP Requirements

Contractors must maintain a roster of PCP providers that may appropriately serve CSHCS enrollees. Contractors should consider the following criteria when designating a PCP as appropriate to serve CSHCS enrollees:

- The PCP should regularly serve children or youth with complex chronic health conditions
- The PCP practice should have a mechanism to identify children/youth with chronic health conditions
- The PCP practice should provide expanded appointments when the child/youth has complex needs and requires more time
- The PCP practice should have experience coordinating care for children/youth who see multiple professionals (pediatric subspecialists, physical therapists, mental health professionals, etc.)
- The PCP practice should have a designated professional responsible for care coordination for children/youth who see multiple professionals

- The PCP practice should indicate willingness to accept new patients (children/youth) with complex chronic health conditions
- The PCP should whenever possible, be appropriate for youth and adults who are transitioning to adulthood

Contractors must obtain a written attestation from PCP providers who are qualified and willing to serve CSHCS enrollees. The attestation must specify that the PCP meets the qualifications stated in the above bulleted list.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

9. Add the following language to the end of the new Section 1.022(S)(4) to read as follows:

Contractors are encouraged to assign CSHCS enrollees to PCP practices that provide family-centered care and family-centered medical homes. Contractors are encouraged to place CSHCS enrollees with PCP practices that utilize the American Academy of Pediatric core principles of patient- and family-centered care.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

10. Revise Section 1.022(W)(1) to read as follows:

(a) Local Organizations and Providers

The Contractor must work closely with local public and private community-based organizations and providers to address prevalent health care conditions and issues. Such agencies and organizations include local health departments, local DHS offices, family planning agencies, Substance Abuse Coordinating Agencies, community and migrant health centers, child and adolescent health centers and programs, and local or regional consortiums centered on various health conditions. Local coordination and collaboration with these entities will make a wider range of essential health care and support services available to the Contractor's enrollees.

To ensure that the services provided by these agencies are available to all Contractors, an individual Contractor must not require an exclusive contract as a condition of participation with the Contractor.

It is also beneficial for the Contractor to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, CAHCPs and FQHCs are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

The Contractor must establish and maintain agreements with all Local Health Departments for CSHCS enrollees in the Contractor's service area to coordinate care. Local Health Departments and the Contractor may share enrollee information to facilitate coordination of care without specific authorization from the enrollee. The enrollee has given consent to share information for purposes of payment, treatment and operations as part of the Medicaid Beneficiary Application.

The agreement must address all of the following topics:

- Data sharing
- Communication on development of Care Coordination Plan
- Reporting requirements
- Quality assurance coordination

- Grievance and appeal resolution
- Dispute resolution
- Transition planning for youth

The Contractor will not be responsible for care coordination services provided by the LHD. The Department of Community Health will continue to provide payment to LHDs for care coordination services. However, both the Contractor and the LHD are mandated to communicate to ensure that a cohesive Care Coordination Plan is established for each CSHCS enrollee

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

11. Revise contract section 1.022(F) by adding the following as a new Section 1.022(F)(22), titled Durable Medical Equipment and Medical Supplies:

Contractors must operate consistently with all applicable Medicaid coverage and limitation policies including Medicaid guidelines for medical necessity of Durable Medical Equipment and Medical Supplies. Contractors must provide the full range of covered services listed in the contract and Contractors may also choose to provide services over and above those specified. However, Contractors are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements in accordance with 1.022(F)(21).Role of Children's Multidisciplinary (CMS) clinics

Proposed contract changes: Revise section 1.022(W), Coordination of Care with Public and Community Providers and Organizations, to add a new section which reads as follows:

The Contractor must establish and maintain a coordination agreement with each CMS clinic facility to ensure coordinated care planning and data sharing, including but not limited to, the assessment, treatment plan and care coordination. Transportation to Children's Multidisciplinary Specialty (CMS) clinics is part of the covered transportation benefit and, as such, must be provided by the Contractor.

DCH is responsible for payment of special facility fees to the CMS clinics; the Contractor is not required to cover these special fees to CMS clinics. However, all covered services provided at the CMS clinic are the responsibility of the Contractor.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

12. Revise contract section 1.022(Y), Payment to contracted providers, to add the requirement that MHPs make a monthly payment to Family Centered Medical Home providers for each CSHCS enrollee. Specifically, add a new subsection 1.022(Y)(8) at the end of the current 1.022(Y) that reads as follows:

Contractors must make special payments to the contracted primary care providers who serve CSHCS enrollees. Specifically, the Contractor must make the following per member per month payments:

- $4 to each primary care provider serving a TANF CSHCS enrollee
- $8 to each primary care provider serving an ABAD CSHCS enrollee

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

13. Modify the first paragraph of 1.022(AA)(2) to read as follows:

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. For prior authorization decisions related to CSHCS enrollees the Contractors are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals and ancillary providers available and appropriate to render services to CSHCS enrollees. The Contractor is also encouraged to utilize Office of Medical Affairs Medical Consultants for assistance in determining appropriate durable medical equipment for CSHCS enrollees.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

14. Revise contract section 1.031 by adding the following as a new Section 1.031(D):

The Contractor must establish and maintain a written procedure and process to obtain information from CSHCS enrollees and families. CSHCS enrollees and families must be given the opportunity to provide input on Contractor policies and/or procedures that influence access to medical services or member services and information. Contractors are encouraged to develop forums for discussion between the CSHCS enrollees and families and the Contractor.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

Section B: Changes for FY13 Due to Policy and Procedure Changes

1. Modify Section 1.022(E) to include re-instated Chiropractic and Vision Service

   - Chiropractic services

Rationale: Legislature re-instated the funding for Chiropractic and Vision services for Medicaid beneficiaries

2. Revise section 1.022(F)(5) to remove the reference to open enrollment.

The Contractor may require co-payments by enrollees, consistent with State and federal guidelines, Medicaid Policy, waivers obtained by DCH, and other DCH requirements. The Contractor must not implement co-payments without DCH approval. Enrollees must be informed of co-payments upon enrollment and upon any changes to co-payment requirements.. Co-payment requirements must be listed in the member handbook.

Rationale: Michigan has moved to rolling open enrollment; therefore co-payment changes may not be tied to an annual open enrollment period.

3. Revise contract 1.022(A) to include beneficiaries who are authorized to receive private duty nursing services among the excluded populations for purposes of MHP enrollment. Specifically, add a bullet under the subtitle "Medicaid Eligible Groups Excluded from Enrollment in the CHCP" in 1.022(A) that reads as follows:

- Persons authorized to receive private duty nursing benefits

Rationale: Most individuals receiving private duty nursing benefits are dual Title V and Title XIX beneficiaries. Individuals with private duty nursing services become an excluded population upon the enrollment of dual Title V/Title XIX individuals into Medicaid Health Plans due to the need to maintain consistency with the regular MHP services package logic

4. Modification Section 1.22(O)(2) to update the review site from Excluded Parties List System (EPLS) to System for Award Management(SAM)

To meet compliance with this subsection, the Contractor must do all of the following:

(1) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

(2) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) at www.sam.gov, the Medicare Exclusion Database (MED), and any such other databases as the Secretary of HHS may prescribe.

(3) (a) Consult appropriate databases to confirm identity upon enrollment and reenrollment
(b) Check the LEIE and SAM and any such other databases as the Secretary of HHS may prescribe, no less frequently than monthly.

(4) Check the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List and the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR) as updates are published.

Rationale: Needed to align with the change by CMS from EPLS to SAM

5. Modification for Fraud and Abuse Contact Information

A Contractor who has any suspicion or knowledge of fraud and/or abuse within any of DCH's programs must report directly to Office of Health Services Inspector General by calling (855) 643- 7283, online at www.michigan.gov/fraud, or in writing to:

Office of Health Services Inspector General
PO Box 30479

The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the enrollees receiving services. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution during the compliance review process.

(1) Reporting of Fraud and Abuse
The Contractor must report all (employee, providers and members) suspected fraud and/or abuse that warrant investigation to Office of Health Services Inspector General.

Additionally, the Contractor must provide the number of complaints warranting a preliminary investigation since the previous compliance review visit. Further, for each complaint warranting full investigation, the Contractor must provide to OHSIG Medicaid Integrity Program the following information:

- The name of the provider, individuals, and/or entity, including their address, phone number and Medicaid identification number, and any other identifying information
- Source of the complaint
- Type of provider
- Nature of the complaint
- Approximate range of dollars involved
- Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred

The Contractor must inform OHSIG of actions taken to investigate or resolve the reported suspicion, knowledge, or action. The Contractor must also cooperate fully in any investigation by OHSIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

The Contractor is permitted to disclose protected health information to, OHSIG or the Department of Attorney General without first obtaining authorization from the enrollee to disclose such information. DCH and the Department of Attorney General shall ensure that such disclosures meet the requirements for disclosures made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.501.

Rationale: Department of Community Health Medicaid Program Integrity Unit moved to the Office of Health Services Inspector General.

6. Updated Appendix 3, 4, and 5 attached

Appendix 3

2013 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

All reports must be **shared** electronically via the **DCH File Transfer Application**.

Exceptions are the encounter data and provider file which are submitted electronically via the DEG.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Consolidated Annual Report	3/1/13	1/1/12 – 12/31/12	Contract 1.042A(2)
• Health Plan Profile (MSA 126 (01/06)) NOTE: **Follow instructions carefully and include all required attachments.** • Health Plan Data Certification Form (MSA 2012 (02/08)). • Litigation (limited to litigation directly naming health plan, MSA 129 (09/99)) • Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms) • Medicaid Certificate of Coverage • Medicaid Member Handbook • EPSDT Requirements: o **Incentives:** List, with brief description, member incentives offered to increase member utilization of EPSDT services; List, with brief description, provider incentives offered to increase monitoring of/providing EPSDT services			
Management Discussion and Analysis for Annual Financial	4/1/13	1/1/12 – 12/31/12	Contract 1.042 A(2)
Audited Financial Statements	6/1/13	1/1/12 – 12/31/12	NAIC, OFIR
QIP Annual Evaluation and Work Plan	8/1/13	Current, Approved 2012 Evaluation, 2013 Work Plan	Electronic Format; Contract 1.022 Z(1-4)
HEDIS® Compliance Audit – Final Audit Report	8/1/13	1/1/12 – 12/31/12	NCQA formatted, electronic copy
HEDIS® IDSS	7/1/13	1/1/12 – 12/31/12	NCQA formatted, electronic copy
• Auditor-locked Excel format Audit Review Table (ART) • Excel Downloads: Comma Separated Values (CSV) Workbook • Excel Downloads: Data-filled Workbook (measure level detail file), and • Copy of MHP's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" lette			
Quarterly Submissions			
Grievance/Appeal	1/30/13 4/30/13 7/30/13 10/30/13	10/1/12 – 12/31/12 1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	MSA 131 (11/11), Grievance & Appeal Log

Report Reference	Due Date	Period Covered	Instructions/Format
Financial	5/15/13 8/15/13 11/15/13	1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	NAIC and OFIR
Third Party Collection	5/15/13 8/15/13 11/15/13	1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	Report on separate sheet and send with NAIC
Monthly Submissions			
Claims Processing	30 days after end of the month NOT last day of month	• Data covers previous month • i.e., data for 2/13 due by 3/30/13	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/13 due by 2/15/13	837 Format NCPDP Format
Provider Files (4275)	Friday before the last Saturday of each month	• Submit all providers contracted with the plan on the date of submission • Submit two files, one utilizing the MA-MC provider voluntary ID and one utilizing the CSHCS-MC provider voluntary ID	4275 layout and file edits distributed by DCH

MEDICAID MANAGED CARE
Medicaid Health Plans
(Contract Year October 1, 2012 – September 30, 2013)

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE).**

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the calendar year.	Combination 3 ≥73%	HEDIS report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥89%	HEDIS report	Annual
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥72%	HEDIS report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥80% continuous enrollment	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥68%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥73%	HEDIS report	Annual

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Customer Services:** Enrollee Complaints ▪	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate ≤0.15 per 1000 member months	Customer Relations Management (CRM)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, ≤1% of ending inventory over 45 days old; ≤ 14% denied claims	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Complete submission	MI Enrolls	Monthly

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

July 9, 2012

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 8

to

CONTRACT NO. 071B0200018

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
CoventryCares of Michigan, Inc.	Beverly Allen	baallen@cvty.com
1333 Gratiot, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48207	(313) 465-1519	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	MDCH	Greg Rivet	(517) 335-5096	
BUYER:	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS	CURRENT EXPIRATION DATE
October 1, 2009	September 30, 2012	3, one year	September 30, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ YES ☒ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:		
OPTION EXERCISED: ☐ NO ☐ YES	IF YES, EFFECTIVE DATE OF CHANGE:	NEW EXPIRATION DATE:
Effective June 1, 2012, the attached Contract Changes for Fiscal Year 2012 are hereby INCORPORATED into this Contract. Effective October 1, 2012, this Contract is hereby INCREASED by $136,527,546.00. All other terms, conditions, pricing, and specifications remain the same. Per Contractor/DCH agreement, DTMB Procurement approval and the approval of the State Administrative Board on July 24, 2012.		
VALUE/COST OF CHANGE NOTICE:	$136,527,546.00	
ESTIMATED REVISED AGGREGATE CONTRACT VALUE:	$759,441,281.69	

Contract Changes for Fiscal Year 2012

Contract Changes are Effective 06/01/2012

1. Provider Payments

Revise Section 1.022(Y) Provider Payment to indicate that the Contractor must cooperate with DCH in initiatives to pay providers for the outreach, education and delivery of prevention services for chronic illness such as obesity and kidney disease. Specifically, add a new paragraph at the end of the introduction to section 1.022(Y) that reads as follows:

> The Contractor must develop programs to facilitate outreach, education and prevention services with both network and out-of-network providers. Contractors shall provide an annual summary of the outreach, education, and prevention services with the Annual Report due on March 1 of each year.

Rationale: Required to implement the June 2012 rate changes.

2. Hospital Payments

Revise Section 1.022(Y)(7), Hospital Services, to include language to incorporate rate changes required by changes in enrollment trends. Specifically, revise the last sentence in the first paragraph of Section 1.022(Y)(7):

> Hospital payments must also include the applicable hospital reimbursement (e.g.Graduate Medical Education (GME) in the amount and on the schedule dictated by DCH.

Rationale: Required to implement the June 2012 rate changes.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **May 15, 2012**
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 7
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **CoventryCares of Michigan, Inc.** **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	TELEPHONE (313) 465-1519 **Beverly Allen** BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Greg Rivet (517) 335-5096 **Comprehensive Health Care Program – Department of Community Health** **(Cass, Kalamazoo, Oakland, St. Joseph, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective June 1, 2012, Omnicare Health Plan, Inc. will change its name to CoventryCares of Michigan, Inc.

Effective as indicated, the attached Contract Changes for Fiscal Year 2012 are hereby INCORPORATED into this Contract (see attachments).

PLEASE NOTE: The Contract Compliance Inspector has been changed to:

Greg Rivet (517) 335-5096
rivetg@michigan.gov

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Procurement approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $622,913,735.69

Contract Changes for Fiscal Year 2012
Contract Changes are Effective 10/01/2011

3. Appendices

Revise Appendix 3, Reporting Requirements, Appendix 4, Performance Monitoring Standards, and Appendix 5 as indicated in attached documents.

Rationale: Updated for fiscal year 2012

4. Health Education

Revise Section 1.022(E)(2), Enhanced Services, to include language to incorporate designated topics of health education. Specifically, revise the first bullet in the bulleted list of the first paragraph to reads as follows

- Place strong emphasis on programs to enhance the general health and well-being of enrollees.
- Specifically, develop and implement programs that encourage enrollees to maintain a healthy diet, engage in regular exercise, get an annual physical examination, and avoid all tobacco use
- Make health promotion programs available to the enrollees
- Promote the availability of health education classes for enrollees
- Provide education for enrollees with, or at risk for, a specific disability or illness
- Provide education to enrollees, enrollees' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities
- Upon request from DCH, collaborate with DCH on projects that focus on improvements and efficiency in the overall delivery of health services

Rationale: Because of the breadth and impact of contracts with Medicaid Health Plans (MHPs), DCH executive management determined that the Governor's health initiatives should be incorporated into the MHP Contract.

5. State of Michigan Department of Community Health Laboratory (DCH Lab)

Revise Section 1.022(W), Coordination of Care with Public and Community Providers and Organization, to reflect a new requirement for Contractors to pay the State of Michigan Department of Community Health Laboratory for specified services. Specifically, revise Section 1.022(W) by adding a new subsection (3) that reads as follows:

> The Contractor must reimburse the State of Michigan Department of Community Health Laboratory (DCH Lab) for specific tests performed for the Contractor's enrollees. The specific tests for which reimbursement is required are listed in Attachment C. The Contractor may not require the DCH Lab to obtain prior authorization for performing the laboratory services. The Contractor is responsible for the reimbursement regardless of prior authorization or the existence of a contract with the DCH Lab. If a contract or agreement is not in effect at the time services are performed, the Contractor is responsible for payment to the DCH Lab at established Medicaid-FFS rates in effect on the date of service.
>
> DCH is responsible for ensuring that the DCH Lab provides all beneficiary-level data related to the tests listed in Attachment C performed by the DCH Lab. For all tests performed after May 1, 2012, the DCH Lab must provide this data to the Contractor within 90 days of performing the test.

Rationale: After discussion with the DCH Contract Administration, DCH Laboratory and the MHPs, DCH determined that placing the requirements into the MHP contract was the most efficient and effective way to meet the reimbursement and data sharing needs of the DCH lab and MHPs.

6. State of Michigan Department of Community Health Laboratory (DCH Lab)

Revise Sections 1.022(E) and 1.022(CC) of the contract to reflect DCH managed care plan division's revised policy and procedure regarding marketing, branding and health promotion. Specifically, the first paragraph after the bulleted list in Section 1.022(E)(2) will be revised to read as follows:

> The Contractor agrees that the enhanced services must comply with the marketing, branding, incentive, and other relevant guidelines established by DCH. Marketing ~~and incentive programs related to health promotion programs~~ must be approved by DCH prior to implementation. DCH will be receptive to innovation in the provision of health promotion services and, if appropriate, will seek any federal waivers necessary for the Contractor to implement a desired innovative program.

Additionally, revise the contract to reflect that health promotion incentives no longer require prior approval from DCH. Specifically, Sections 1.022(CC)(1) and 1.022(CC)(4) will be revised to read as follows:

CC. Marketing

(1) General Information

The Contractor may promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of an entire city, an entire county, or larger population segment in the Contractor's approved service area. Additionally, the Contractor may provide incentives, consistent with State law, to enrollees in the Contractor's plan that encourage healthy behavior and practices. All marketing ~~and health promotion incentives~~ must be approved by DCH prior to implementation. If the Contractor has previously received approval for a specific marketing ~~or health promotion incentive~~ and wishes to repeat the same marketing ~~or health promotion incentive~~, the Contractor is not required to seek DCH approval. The Contractor must notify DCH of the intention to repeat the marketing ~~or incentive~~, prior to implementation, and attest that the marketing ~~or incentive~~ is identical to the program previously approved by DCH.

(4) Marketing materials

All written and oral marketing materials ~~and health promotion incentive materials~~ must be approved by DCH prior to use. Upon receipt by DCH of a complete request for approval that proposes allowed marketing practices and locations, DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. The review clock will be tolled while the Contractor revises materials for re-submission.

Rationale: Update contract to align with revised policy and procedure,

Attachment C

Test	CPT
Chlamydia NAAT	87491
Gonorrhea NAAT	87591
Hepatitis B	86706, 87340
Hepatitis C	86803, 86804
Herpes Culture	87274, 87273
Syphilis serology	87164
Fungal identification	87107, 87101, 87102
Yeast identification	87106
Ova and Parasite	87169, 87172, 87177, 87206,87207, 87209
Bacterial identification	87077, 87076

Appendix 3

2012 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

- Reports must be submitted to the contract manager; **exceptions** are the encounter data and provider file which are submitted electronically via the DEG and the monthly claims report which is submitted via E-mail to wolfs@michigan.gov.
- Reports must be submitted as required above (not other Departments or Sections) to be logged as received.

Report	Due Date[4]	Period Covered	Instructions/Format
ANNUAL			
Consolidated Annual Report[1]	3/1/12	1/1/11 - 12/31/11	Contract 1.042 A(2) and footnote 1 on p. 2
Management Discussion and Analysis for Annual Financial	4/1/12	1/1/11 - 12/31/11	Contract 1.042 A(2)
Audited Financial Statements	6/1/12	1/1/11 - 12/31/11	NAIC, OFIR
HEDIS® IDSS[2]	6/30/12	1/1/11 - 12/31/11	NCQA formatted, electronic copy
HEDIS Compliance Audit Report[3]	7/30/12	1/1/11 - 12/31/11	NCQA formatted, electronic copy
QIP Annual Evaluation and Work Plan	6/30/12	Current, Approved 2011 Evaluation, 2012 Work Plan	Electronic Format; Contract 1.022 Z(1-4)
QUARTERLY			
Grievance/Appeal	1/30/12 4/30/12 7/30/12 10/30/12	10/1/11 - 12/31/11 1/1/12 – 3/31/12 4/1/12 - 6/30/12 7/1/12 – 9/30/12	MSA 131(11/11)
Financial	5/15/12 8/15/12 11/15/12	1/1/12 - 3/31/12 4/1/12 - 6/30/12 7/1/12 - 9/30/12	NAIC and OFIR
Third Party Collection	5/15/12 8/15/12 11/15/12	1/1/12 - 3/31/12 4/1/12 - 6/30/12 7/1/12 - 9/30/12	Report on separate sheet & send w/ NAIC
MONTHLY			
Claims Processing	30 days after end of month *NOT last day of month*	•Data covers previous month •i.e., data for 2/12 due by 3/30/12	MSA 2009(E) (11/03)
Encounter Data	The 15th of each month	•Minimum of Monthly •Data covers previous month •i.e., data for 1/12 due by 2/15/12	837 Format NCPDP Format
Provider File (4275)	Friday before the last Saturday of each month	•Submit all providers contracted with the plan on the date of submission	4275 layout and file edits distributed by DCH

Notes

1. Annual Report Components
   - Health Plan Profile (MSA 126 (01/06)) *NOTE:* ***Follow instructions carefully and include all required attachments.***
   - Financial (NAIC, all reports required by OFIR, and Statement of Actuarial Opinion are due with the annual report on 3/1/12). *NOTE: The Management Discussion and Analysis is due 4/1/12 and the Audited Financial Statements are due 6/1/12.*
   - Health Plan Data Certification Form (MSA 2012 (02/08)); must submit **signed original** copy; fax and electronic copies of this form are not acceptable
   - Litigation (limited to litigation directly naming health plan, MSA 129 (09/99))
   - Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms)
   - Medicaid Provider Directory; **include an electronic copy of the provider directory on compact disc**
   - Medicaid Certificate of Coverage
   - Medicaid Member Handbook
   - EPSDT Requirements (see below)
2. **Due on 6/30/12:** Audited Medicaid HEDIS IDSS (Interactive Data Submission System) output, per NCQA submission protocol electronically, includes:
   - Auditor locked Excel format Audit Review Table (ART),
   - Excel Downloads: Comma Separated Values (CSV) Workbook,
   - Excel Downloads: Data-filled Workbook (measure level detail file), and
   - Copy of the MHP's signed and dated "Attestation of Accuracy and Public Reporting Authorization-Medicaid" letter
3. **Due on 7/30/12**: HEDIS Compliance Audit Report and certified auditor's signed and dated Final Audit Statement.
4. If due date is not a business day, reports received on the next business day will be considered timely

EPSDT Settlement Reporting Requirements

Please submit the following materials as part of the Annual Report due March 1, 2012

1. **Educational Materials:** Copy of all educational documents used by the plan to inform children/guardians of availability of EPSDT services, age-appropriate immunizations and assistance from the health plan on accessing EPSDT services
2. **Transportation Policy:** Copy of plan's policy/policies that govern administration of the transportation benefit
3. **Incentives:** List and brief description of member incentives offered to increase member utilization of EPSDT services; list and brief description of provider incentives offered to increase provider monitoring of / providing EPSDT services
4. **EPSDT Report Template:** Complete report template (MSA 0236 (08/10))
   - Access Standards for Waiting Times (to schedule appointments *and* to be seen after appointment time) for Primary Care Physician (PCP)
   - Transportation Services
   - EPSDT Outreach

MEDICAID MANAGED CARE
Medicaid Health Plans
(Contract Year October 1, 2011 – September 30, 2012)

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE)**.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the calendar year.	≥72% Combination 3	HEDIS report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥88%	HEDIS report	Annual
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥70%	HEDIS report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥80% continuous enrollment	MDCH Data Warehouse	Monthly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥67%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥72%	HEDIS report	Annual

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Customer Services:** Enrollee Complaints ▪	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate ≤.20% per 1000 member months	Customer Relations Management (CRM)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, ≤1% of ending inventory over 45 days old; ≤ 14% denied claims	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Complete submission	MI Enrolls	Monthly

Appendix 5
2012 Bonus Template - DCH Focus PCMH

Category	Description	2012 Payout Report due: 6/12 Projected payout: 12/12
Patient Centered Medical Home (PCMH) **40 points**	The Health Plan actively supports engagement and transition of primary care practices to Patient Centered Medical Homes by aligning provider incentive programs with PCMH focus areas: I. ePrescribing II. Patient Registry III. Expanded Access	FY 2012 P4P must include all three focus areas. MHP report will: • Identify provider groups targeted for incentive program • Describe the P4P program for each focus area • Identify amount targeted for PCMH payout • Provide documentation that verifies plan efforts in applicable focus area. (i.e., reports/screen shots from e-prescribe interface, de-identified reports from patient registry, reminder/recall letters from patient registry) • Provide documentation of expanded access strategy. (process to evaluate providers targeted and implementing access standards; e-appointments)

Appendix 5
2012 DCH P4P Bonus

Category	Description	2012 Payout Report due: 7/31/12 Projected payout: 12/12
Patient-Centered Medical Home: Practice Transformation - Care Coordination **$ Balance of Bonus withhold**	The 2012 Pay for Performance project will require the MHPs to respond to a survey. The survey will ask about MHP programs and services that assist practices with Care Coordination. The advancement of the PCMH foundational work in MI to focus on the same strategies. The specific PCMH initiatives that will be addressed is Care Coordination	The Michigan Medicaid Health Plan (MHP) has the opportunity to receive this P4P bonus award for completion of a survey designed to glean base-line information about each plan's current care coordination initiatives. The MHP will respond to questions regarding programs and services that assist practices in a number of key areas including but not limited to: • Care plans • medication reconciliation • test tracking • referral follow-up • transitions of care • team-based care • identification of high-risk patients

Health Plan Name	FY 12 Performance Bonus Template Appendix 5		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2012 HEDIS	**2012 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds- Ages 5-11		0	0.0%	0.0%	0.0%
Adult BMI		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Other					
Children BMI					
Childhood - Combo3		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2012 HEDIS	**2012 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%
7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	**Last CAHPS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%****	**75%****	**90%****
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%
Advising Smokers and Tobacco Users to Quit		0	0.0%	0.0%	0.0%
Smoking Measures	**Score**	**50% (1 point); 75% (2 points); 90% (3 points)**	**50%**	**75%**	**90%**
Tobacco Cessation Strategies		0	0.0%	0.0%	0.0%
Medical Assistance with Smoking and Tobacco		0	0.0%	0.0%	0.0%

Accreditation Status - 2011	**Accredited or Conditional as of 12/31/11 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/11 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/11 (10 Pts)**
Org Name (Date of visit)			
Total Member Months of Enrollment by Age and Sex - HEDIS 2010	**0**		

Summary	Possible Points	Health Plan Points
Clinical Measures (42.0%)	68	0.0
Access to Care (15.0%)	24	0.0
Survey Measures (CAHPS) (13.0%)	22	0.0
Accreditation Status (6.0%)	10	0.0
Focus Study Requirements (24.0%)	40	0.0
Performance Bonus Total Score	164	0.0

DCH Focus (Total 40 Pt.)	Score	Incentive Points
PCMH	0.0%	0.0
Total Points		

CAHPS Survey Measures

** based on 2011 NCQA Quality Compass Public Report Rate.

Contract Changes for Fiscal Year 2012
Contract Changes are Effective 6/01/2012

1. Chiropractic Services

Revise 1.022(E)(1), Covered Services in response to Policy Bulletin MSA 12-14 which reinstated coverage for adult chiropractic benefits. Specifically, remove the parenthetical statement after "Chiropractic services" in the covered benefits list as follows:

- Chiropractic services ~~(only for enrollees under 21 years of age)~~

Rationale: MSA Bulletin 12-14 stated that effective for dates of service on and after June 1, 2012, the Michigan Department of Community Health (MDCH) is reinstating coverage for the adult chiropractic benefit for beneficiaries age 21 years and older as required by Public Act 89 of 2012.

CONTRACT #071B0200018
OMNICARE HEALTH PLAN

ATTACHMENT A
APPROVED SERVICE AREA

Oakland #63
Wayne #82

8/1/2011

Kalamazoo #39
St. Joseph #75

10/1/2011

Cass #14

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **March 22, 2012**
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 6
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **CoventryCares of Michigan, Inc.** **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	TELEPHONE (313) 465-1519 **Beverly Allen** BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Penny Saites (517) 335-5036 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Pursuant to Contract Section 2.002 OPTION TO RENEW, the Contract terms for each contractor who is party to a contract with the State for the Comprehensive Health Care Program—Department of Community Health, will be immediately extended for an additional one-year period, until September 30, 2013.

In consideration for this Contract term extension, Contractor releases and forever discharges the State of Michigan in its broadest sense, including its public bodies, boards, agencies, departments, and divisions, and its employees, officers, attorneys, and representatives, from all actual and potential claims, causes of action, damages, and other liabilities of direct or indirect, known or unknown, arising out of, caused by, or otherwise related in any way to the State's approval of BlueCaid's request for expansion into the remainder of Wayne County.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Procurement approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $622,913,735.69

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET September 13, 2011
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Penny Saites (517) 335-5036 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective as indicated, the attached Contract Changes for Fiscal Year 2012 are hereby incorporated into this Contract (see attachments).

The Contract Compliance Inspector has been changed to Penny Saites, (517-335-5036, saitesp@michigan.gov) and the Project Manager has been changed to Kathleen Stiffler (517-241-7933, stifflerk@michigan.gov). Please note that the buyer has been CHANGED to Lance Kingsbury.

Effective September 15, 2011, this contract is hereby INCREASED by $406,628,021.40.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Purchasing Operations' approval and the approval of the State Administrative Board on September 15, 2011.

INCREASE: $406,628,021.40

TOTAL REVISED ESTIMATED CONTRACT VALUE: $622,913,735.69

Contract Changes for Fiscal Year 2012
Contract Changes are Effective 10/01/2011
EXCEPTION: Contract Change #33 for Dual Eligible Population is Effective 11/01/2011

Section One

Section one contains revisions required by the Center for Medicaid and Medicare Services (CMS) pursuant to the review of the FY2011 contract.

1. Definitions

The following definitions were added to the Definition of Terms section of the Contract:

> Agent - Any person who has express or implied authority to obligate or act on behalf of the Contractor, Subcontractor, or network provider.
>
> Cold Call Marketing - Any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing.
>
> Fiscal Agent - Subcontractor that processes or pays claims on behalf of the Contractor.
>
> Marketing Materials - Materials that are produced in any medium, by or on behalf of the Contractor, that can reasonably be interpreted as intended to market to potential enrollees.
>
> Women's Health Specialist – A health care professional that specializes in providing women's health services.

Rationale: Required by CMS per 42 CFR 438.104(a) and 42 CFR 438.206(b)(2)

2. Enrollee Acceptance

Specify that Contractors must accept enrollees in the order in which they apply without restriction. Specifically, MI inserted the following sentence as the second sentence in the third paragraph of 1.022A(2):

> The Contractor must accept enrollees for enrollment in the order in which they apply without restriction.

Rationale: Required by CMS per 42 CFR 438.6 (d)(1)

3. Notification of Disenrollment Rights

Clarify notification to enrollees' of disenrollment rights during open enrollment. Specifically, MI revised 1.022(A)(3)(a) to read as follows:

> Sixty days prior to the annual open enrollment period, DCH, or the Enrollment Services Contractor, will notify enrollees of their right to disenroll

Rationale: Required by CMS per 42 CFR 438.10(f)

4. Enrollee Requests for Disenrollment

Add language to specify when enrollee's may request disenrollment for cause. Specifically, MI revised the bulleted list under Section 1.022(C)(2) to read as follows:

a. Enrollee's current health plan does not, because of moral or religious objections, cover the service the enrollee seeks and 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 network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
b. Lack of access to providers or necessary specialty services covered under the Contract. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor.
c. Concerns with quality of care.

Rationale: Required by CMS per 42 CFR 438.56(c)

5. <u>Continuation of Services</u>
Clarified that Contractors must cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Specifically, added a new bullet in Section 1.022(D) that reads as follows:

- The Contractor must cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge as specified by Medicaid policy.

<u>Rationale:</u> Required by CMS per State Medicaid Manual 2086.6.B

6. <u>Covered Services</u>
Delineate Contractors must cover medically necessary services and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Specifically, the first paragraph of Section 1.022(E)(1) was revised to read as follows:

(1) Covered Services
The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care, but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

<u>Rationale:</u> Required by CMS per 42 CFR 438.210(a)(4)

7. <u>Emergency Services</u>
Expand the Contract provisions regarding emergency services to include all portions of the 42 CFR 438.114. Section 1.022(F)(1) was revised to read as follows:

(1) *Emergency Services*
The Contractor must cover emergency services as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USC 1395dd(a)). The enrollee must be screened and stabilized without requiring prior authorization.

The Contractor must ensure that emergency services are available 24 hours per day and seven days per week. The Contractor is responsible for payment of all out-of-plan or out-of-area emergency services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services. The Contractor may not refuse to cover emergency services based on the emergency department provider or hospital not notifying the enrollee's primary care provider or Contractor of the enrollee's services in the emergency department. Unless a representative of the Contractor instructed the enrollee to seek emergency services, the Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.

(a) Emergency Transportation
The Contractor must provide emergency transportation for enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, the emergency transportation provider must submit a properly completed and coded claim form for emergency transport, which includes an appropriate ICD-9-CM diagnosis code as described in Medicaid Policy.

(b) Emergency Professional Services
The Contractor must provide professional services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard. The Contractor acknowledges that hospitals offering emergency services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. The Contractor further acknowledges that if an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the enrollee.

(c) Emergency Facility Services

The Contractor must ensure that emergency services continue until the enrollee is stabilized and can be safely discharged or transferred. The Contractor is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the Contractor's network that are pre-approved by a Contractor provider or other Contractor representative. The Contractor is also financially responsible for post-stabilization care services obtained within or outside the Contractor's network that are not pre-approved by a Contractor provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

If an enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services.

However, such services shall be deemed prior authorized under any of the following conditions:

i. If the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) for responding to a request for authorization being made by the emergency department,
ii. If the Contractor is not available for the hospital to contact to request prior authorization for post-stabilization services
iii. If the Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria specified below is met.

The Contractor's financial responsibility for post-stabilization care services that have not been pre-approved ends when any of the following conditions are reached:

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

Additionally, the Contractor is responsible for all services administered to maintain the enrollee's stabilized condition within 1 hour of a request for pre-approval of further post-stabilization care services.

Rationale: Required by CMS per 42 CFR438.114, State Medicaid Director Letter 2/20/98, and 42 CFR 422.133(c)(2).

8. Blood Lead Testing

The October 22, 1999 State Medicaid Director letter requires States to provide all Medicaid-eligible children with a screening blood lead test at 12 and 24 months of age. In addition to the performance monitoring requirements regarding blood lead testing in Appendix 4, MI modified Section 1.022(F)(8), 7th bullet to read as follows:

- Blood lead testing for children under six years of age; children must be tested by 12 months of age and 24 months of age.

Rationale: Required by CMS per State Medicaid Director Letter of October 22, 1999

9. Oral and Written Interpretation

Delineate oral interpretation services apply to all non-English languages, not just those languages that meet the definition of prevalent language under the Contract (xxiii and xxiv). MI added the word "All" at the beginning of 1.022(H)(1) and separated the requirement for oral interpretation services and written

materials into two criteria under 1.022(H)(3)(b) Additionally, MI added the following sentences to the second paragraph of 1.022(H)(1):

> Oral interpretation services must be available free of charge to all enrollees. This applies to all non-English languages, not just those languages that meet the definition of prevalent language under this Contract.

MI revised the bullets under 1.022(H)(3) for oral and written interpretation services to read as follows:

- How to obtain oral interpretation services for all languages, not just prevalent languages as defined by the Contract
- How to obtain written information in prevalent languages, as defined by the Contract

Rationale: Required by CMS per 42 CFR 438.10(c)(3), (4), and (5).

10. Women's Routine and Preventive Health Services

Clarify that women's routine and preventive health services may be more expansive than OB/GYN. Specifically, MI revised section 1.022(H)(3)(b)(viii) to read as follows:

- Enrollees' right to direct access to network women health specialists and pediatric providers for routine and preventive health care services without a referral

Rationale: Required by CMS per 42 CFR 438.206(b)(2)

11. Enrollee Right To Request Information

Include specific language requiring the Contractor to inform enrollees of their right to request to request information on the structure and operation of the Contractor. Specifically, MI added the following bullet to the information required in the member handbook (Section 1.022(H)(3)(b):

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

Rationale: Required by CMS per 42 CFR 438.10(g)(1)(vii)(3)

12. Certain Non-Covered Services

Include more specific language on the Contractor's responsibilities for providing information on how and where to obtain the counseling or referral services that the Contractor does not cover because of moral or religious objections. Specifically, MI added the following bullet to the information required in the member handbook Section 1.022(H)(3)(b):

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

Rationale: Required by CMS per 42 CFR 438.10(f)

13. Toll Free Number for Grievance and Appeals

Provide specific language requiring the Contractor to provide a toll-free number that enrollees may use to file a grievance or appeal by telephone. Specifically, MI added the following bullet to the information required in the member handbook (Section 1.022(H)(3)(b)):

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

Rationale: Required by CMS per 42 CFR 438.10(g)(1)(v)

14. Grievance and Appeal Requirements

Expand the Contract provisions regarding grievances and appeals to include all requirements specified in 42 CFR 438. Section 1.022(I) is revised to read:

I. Grievance and Appeal Policies and Procedures

(1) *Contractor Grievance/Appeal Policy Requirements*

The Contractor must establish and maintain an internal process for the resolution of grievances and appeals from enrollees. Enrollees may file a grievance or appeal, orally or in writing, on any aspect of covered services as specified in the definitions of grievance and appeal.

The Contractor must have written policies and procedures governing the resolution of grievances and appeals. DCH must approve the Contractor's grievance and appeal policies prior to implementation. These written policies and procedures will meet the following requirements:

(a) Except as specifically exempted in this Section, the Contractor must administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F).
(b) The Contractor must cooperate with the Michigan Office of Financial and Insurance Regulation (OFIR) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act".
(c) The Contractor must make a decision on non-expedited grievances or appeals within 35 calendar days of receipt of the grievance or appeal. This timeframe may be extended up to 10 business days if the enrollee requests an extension or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the enrollee's interest. If the Contractor utilizes the extension, the Contractor must give the enrollee written notice of the reason for the delay. The Contractor may not toll (suspend) the time frame for grievance or appeal decisions other than as described in this Section.
(d) If a grievance or appeal is submitted by a third party, but does not include a signed document authorizing the third party to act as an authorized representative for the beneficiary, the 35-day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the beneficiary that an authorized representative form or document is required. For purposes of this Section "third party" includes, but is not limited to, health care providers.

(2) *Grievance and Appeal Procedure Requirements*

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

(a) Allow enrollees 90 days from the date of the adverse action notice within which to file an appeal under the Contractor's internal grievance and appeal procedure.
(b) Give enrollees assistance in completing forms and taking other procedural steps. The Contractor must provide interpreter services and TTY/TDD toll-free numbers.
(c) Acknowledge receipt of each grievance and appeal.
(d) Ensure that the individuals who make decisions on grievances and appeals are individuals who were:
    i. Not involved in any previous level of review or decision-making and
    ii. Health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease when the grievance or appeal involves a clinical issue.
(e) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
(f) Allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records.
(g) Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.
(h) Notify the enrollee in writing of the Contractor's decision on the grievance or appeal.

(3) *Notice to Enrollees of Grievance Procedure*

The Contractor must inform enrollees about the Contractor's internal grievance procedures at the time of initial enrollment and any other time an enrollee expresses dissatisfaction by filing a grievance with the Contractor. The information will be included in the member handbook and will explain:

(a) How to file a grievance with the Contractor
(b) The internal grievance resolution process

(4) *Notice to Enrollees of Appeal Procedure*

The Contractor must inform enrollees about the Contractor's appeal procedure at the time of initial enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to appeal under the definition of appeal in this Contract. The information will be included in the member handbook and will explain:

(a) How to file an appeal with the Contractor
(b) The internal appeal process
(c) The member's right to a Fair Hearing with the State

When the Contractor makes a decision subject to appeal, as defined in this Contract, the Contractor must provide a written adverse action notice to the enrollee and the requesting provider, if applicable. Adverse action notices for the suspension, reduction, or termination of services must be made at least 12 days prior to the change in services. The Contractor must continue the enrollee's benefits if all of the following conditions apply:

(a) The appeal is filed timely, meaning on or before the later of the following:
    i. Within 10 days of the Contractor's mailing the notice of action
    ii. The intended effective date of the Contractor's proposed action
(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
(c) The services were ordered by an authorized provider
(d) The authorization period has not expired
(e) The enrollee requests extension of benefits

If the Contractor continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

(a) The enrollee withdraws the appeal
(f) The enrollee does not request a fair hearing within 10 days from when the MCO mails an adverse MCO decision
(b) A State Fair Hearing decision adverse to the enrollee is made
(c) The authorization expires or authorization service limits are met

If the Contractor reverses the adverse action decision or the decision is reversed by a State Fair Hearing, the Contractor must pay for services provided while the appeal was pending and authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(5) *Adverse Action Notice*

Adverse action notices involving service authorization decisions that deny or limit services must be made within the time frames described in Section 1.022(AA) of this Contract. Adverse action notices pursuant to claim denials must be sent on the date of claim denial. The notice must include the following components:

(a) The action the Contractor or Subcontractor has taken or intends to take
(b) The reasons for the action
(c) The enrollee's or provider's right to file an appeal
(d) An explanation of the Contractor's appeal process
(e) The enrollee's right to request a Fair Hearing
(f) The circumstances under which expedited resolution is available and how to request it
(g) 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

Written adverse action notices must also meet the following criteria:

(a) Be translated for the individuals who speak prevalent non-English languages as defined by the Contract
(b) Include language clarifying that oral interpretation is available for all languages and how the enrollee can access oral interpretation services
(c) Use easily understood language written below the 6.9 reading level
(d) Use an easily understood format
(e) Be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs

(6) *State Medicaid Appeal Process*

The State will maintain a Fair Hearing process to ensure that enrollees have the opportunity to appeal decisions directly to the State. Any enrollee dissatisfied with a State agency determination denying a beneficiary's request to transfer plans/disenroll has access to a State Fair Hearing. The Contractor must include the Fair Hearing process as part of the written internal process for resolution of appeals and must describe the Fair Hearing process in the member handbook. The parties to the State Fair Hearing may include the Contractor as well as the enrollee and her or his representative or the representative of a deceased enrollee's estate.

(7) *Expedited Appeal Process*

The Contractor's written policies and procedures governing the resolution of appeals must include provisions for the resolution of expedited appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:

(a) The enrollee or provider may file an expedited appeal either orally or in writing
(b) The enrollee or provider must file a request for an expedited appeal within 10 days of the adverse determination
(c) The Contractor must make a decision on the expedited appeal within 72 hours of receipt of the expedited appeal. If the enrollee requests an extension, the Contractor should transfer the appeal to the standard 35-day time frame and give the enrollee written notice of the transfer within two days of the extension request
(d) The Contractor must give the enrollee oral and written notice of the appeal review decision
(e) If the Contractor denies the request for an expedited appeal, the Contractor must transfer the appeal to the standard 35-day timeframe and give the enrollee written notice of the denial within two days of the expedited appeal request
(f) The Contractor must not take any punitive actions toward a provider who requests or supports an expedited appeal on behalf of an enrollee

Rationale: Required by CMS per 42 CFR 438.10, 42 CFR 438.210, 42 CFR 438.402, 42 CFR 438.404, 42 CFR 438.406, 42 CFR 438.420, and 42 CFR 438.424

15. For Cause Disenrollment

Clarify that enrollees may be granted a for cause disenrollment if the Contractor does not, because of moral or religious objections, cover the service the enrollee seeks and reporting requirements specified by Social Security Act. Specifically, Section 1.022(L)(5), Compliance with CMS Regulations, was revised to read as follows:

The Contractor is required to comply with all CMS regulations, including, but not limited to, the following:

(a) Enrollment and disenrollment: As required by 42 CFR 438.56(d)(2), the Contractor must meet all the requirements specified for enrollment and disenrollment limitations. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover as follows:
   - To the State
   - With the Contractor's application for a Medicaid contract
   - Whenever the Contractor adopts the policy during the term of the Contract

   Such notification must meet the following requirements:
   - Be consistent with the provisions of 42 CFR 438.10
   - Be provided to potential enrollees before and during enrollment
   - Be provided to enrollees within 90 days after adopting the policy with respect to any particular service.

(b) Provision of covered services: As required by 42 CFR 438.102(a) and (b), the Contractor is required to provide all covered services listed in **Section 1.022(E) and 1.022(F)** of the Contract. A Contractor electing to withhold coverage as allowed under this provision must comply with all notification requirements
(c) Reporting: As required by Section 1903(m)(4)(A) of the Social Security Act, and delineated further in State Medicaid Manual 2087.6(A-B), the Contractor must report specified transactions to parties of interest.

Rationale: Required by CMS per 42 CFR 438.56(d)(2), 1903(m)(4)(A) of the Social Security Act, and the State Medicaid Manual SMM 2087.6(A-B)

16. Enrollee Rights

Clarify that Contractors must develop enrollee rights policies that includes enrollee rights as specified in 42 CRF 100(a)(1) and that the enrollee is free to exercise her rights, and that the exercise of those rights does not adversely affect the way the Contractor nor providers treat the enrollee. Specifically, MI added a new Section 1.022(N)(3) which states as follows:

> Enrollee Rights
> The Contractor must develop and maintain a written policy regarding enrollee rights. These rights must be communicated to enrollees in the member handbook. The enrollee rights must include, as a minimum, the enrollee's right to:
> a. Confidentiality
> b. Participate in decisions regarding her health care, including the right to refuse treatment and express preferences about treatment options
> c. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
> d. Request and receive a copy of her medical records, and request that they be amended or corrected
> e. Be furnished healthcare services consistent with this Contract and State and federal regulations
> f. Be free to exercise her rights without adversely affecting the way the Contractor, providers or the State treats the enrollee
> g. Be free from other discrimination prohibited by State and federal regulations

Additionally, MI revised the numbered bullet regarding enrollee rights under 1.022(H)(3) to read as follows:

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

Rationale: Required by CMS per 42 CFR 438.100(a)(1) and 42 CFR 438.100(c)

17. Anti-gag Clause

Specify that the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient. Specifically, MI revised Section 1.022(U)(1)(e) to require the following provisions to be included in the Contracts between the Contractor and the Contractor's providers:

> (e) Include provisions stating that providers, acting within the lawful scope of practice, are not prohibited, or otherwise restricted, from advising or advocating on behalf of an enrollee who is his or her patient:
> h. For the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
> i. For any information the enrollee needs in order to decide among all relevant treatment options
> j. For the risks, benefits, and consequences of treatment or non-treatment
> k. For the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

Rationale: Required by CMS per 1932(b)(3)(D), 42 CFR438.102(a)(1)(i), (ii), (iii) and (iv), and State Medicaid Director letter 2/20/98

18. Hospital Contracts

Clarify that contracts between the Contractor and hospital providers must require each hospital furnishing inpatient services to have in effect a written UR plan that meets the requirements under 42 CFR 456.101-145. Specifically, MI added the following language to 1.022(U)(i):

> (i) Hospital contracts must contain a provision that mandates the hospital to comply with all medical record requirements contained within 456.101 through 456.145

Rationale: Required by CMS per 42 CFR 456.111 and 42 CFR 456.211

19. Provider Network

Clarify that if a Contractor declines to include individual or groups of providers in its network, the Contractor must give the affected providers written notice of the reason for its decision. Specifically, MI moved the following phrase from 1.022(V)(2) to Section 1.022(U) to clarify that the phrase applies to provider enrollment as well as provider credentialing

> If the plan declines to include providers in the plan's network, the plan must give the affected providers written notice of the reason for the decision.

Rationale: Required by CMS per 42 CFR 438.10(g)(1)(vii)(3**)**

20. Provision of Grievance and Appeal Policies to Providers and Subcontractors

Add requirements for Contractors to provide specific grievance, appeal, and fair hearing procedures and timeframes to all providers and Subcontractors at the time they enter into a contract. Specifically, a new section entitled "Provision of Grievance, Appeal and Fair Hearing Procedures to Providers" was added to the end of Section 1.022(U) that reads as follows:

> The Contractor must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and Subcontractors at the time they enter into a contract:
>
> (a) The enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing
> (b) The enrollee's right to file grievances and appeals and their requirements and timeframes for filing
> (c) The availability of assistance in filing
> (d) The toll-free numbers to file oral grievances and appeals
> (e) The enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Contractor's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits

Rationale: Required by CMS per 42 CFR 438.414 and 42 CFR 438.10(g)(1)

21. Dissemination of Clinical Practice Guidelines

Clarify that clinical practice guidelines must be provided to enrollees upon request. Specifically, MI added the following phrase to Section 1.022(Z)(b)(vii):

> …and makes these clinical practice guidelines available to enrollees upon request…

Rationale: Required by CMS per 42 CFR 438.236(c)

22. Enrollee Notification of Extension of Utilization Time Frame

Clarify that notification to the Enrollee of the Contractor's decision to extend the timeframe of a utilization decision must be made in writing. The revised section also specifies that failure to make a decision within the mandated timeframe is an adverse action. Therefore, the Contractor must send an adverse action notice to the Enrollee. Specifically, MI added the phrase "in writing" to the second paragraph between "The enrollee must be notified" and "of the plan's intent to extend the time frame" to ensure that notification to the enrollee is made in written form. Additionally, MI added the following sentence to the end of Section 1.022(AA)(2):

> If an authorization decision is not made within the specific timeframes, the Contractor must issue an adverse action notice as described in Section 1.022(I).

Rationale: Required by CMS per 42 CFR 438.210(c), 42 CFR 438.210(d)(1), and 42 CFR 438.404(c)(3) and 42 CFR 438.404(c)(4)

23. Sanctions

Delineate that sanctions may be applied for excessive charges or any violation of 1903(m) or 1932 of the Act and add specific language regarding types of sanctions that may be utilized. Specifically, MI modified the eighth bullet of Section 1.022(EE) and added a new bullet. These bullets read as follows:

- Financial requirements including, but not limited to, failure to comply with physician incentive plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program.

- Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

Additionally, MI added specific bullets to the third paragraph of Section 1.022. The third paragraph reads as follows:

DCH may utilize intermediate sanctions (as described in 42 CFR438.700) that may include the following:

- Civil monetary penalties in the following specified amounts:
  - A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
  - A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
  - A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
  - A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging co-payments in excess of the amounts permitted under the Medicaid program. The State will deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).
- Appointment of temporary management for a Contractor as provided in 42 CFR 438.706. If a temporary management sanction is imposed, DCH will work concurrently with OFIR.
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
- Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the sanction.
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

Rationale: Required by CMS per 1903(m)(4)(A), 1903(m)(5)(A) and (B), 1932(e)(1) and (2), 42 CFR 422.208, 42 CFR 422.210, 42 CFR 438.700, 42 CFR 438.702, 2 CFR 438.704, and 45 CFR 92.36(i)(1)

24. NPI Reporting

Confirm that Contractors must collect unique physician identifiers and utilize the identifiers for purposes of encounter reporting. Specifically, the following sentence was inserted at the beginning of the first paragraph of Section 1.042(A)(5):

The Contractor must utilize National Provider Identifier (NPI) to track services and submit encounter data.

Rationale: Required by CMS per Section 1932(d)(4) of the Social Security Act.

25. Grievance and Appeal Reporting

Change the time frame for grievance and appeal reporting from semi-annually to quarterly. MI also revised the format of the report to include reporting of expedited grievances changed to the regular time frame due to enrollee request. Specifically, revise 1.042(A)(7) heading to read as follows:

(7) *Quarterly Grievance and Appeal Report*

Rationale: State law is silent about allowing a 10-day extension for expedited grievances; OFIR policy is to switch the appeal to the standard timeline. So, when an enrollee requests an extension of an expedited appeal, OFIR and DCH agreed to be guided by the language in 42 CFR 438.410 and require the MCO to deny review of the expedited appeal, transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). Because the Contract does not have explicit extension language for expedited appeals, CMS has stipulated that MI must provide quarterly data to CMS on grievance and appeals and provide specific information on expedited grievances changed to the regular time frame due to enrollee request.

Section Two

Section two contains revisions required in response to the CMS Program Integrity Review. The revisions include new Contract language requiring disclosures and increased fraud, abuse, and waste monitoring. Additionally, the Contract has been restructured to include all disclosure requirements in a new Contract section dedicated to disclosure requirements.

26. Definitions

The following definition was added to the Definition of Terms section of the Contract:

> Agent - Any person who has express or implied authority to obligate or act on behalf of the Contractor, Subcontractor, or network provider

Rationale: The term "agent" is used throughout the revised program integrity section.

27. Rename Section
Section 1.022(O)(2) was renamed to "Reporting of Fraud and Abuse"

Rationale: Clarification of purpose of the section

28. Monitoring Time Lines
Clarify that the Fraud and Abuse monitoring time lines are aligned with the compliance review visits. Specifically, the final sentence of 1.022(O)(1) is modified to read as follows:

> DCH will monitor EOB distribution during the compliance review process..

Also, the first sentence in the second paragraph of 1.022(O)(2) is modified to read as follows:

> Additionally, the Contractor must provide the number of complaints warranting a preliminary investigation since the previous compliance review visit.

Rationale: Clarification of time lines

29. Prohibited Affiliations
Move language regarding prohibited affiliations from Section 1.022(L) to Section 1.022(O) and updated all relevant references throughout the Contract. MI added "agent" to the list of covered entities. Additionally, MI added new language to clarify Contractor requirements regarding checking databases for individual debarred from participation. Specifically, Section 1.022(O)(3) now reads as follows:

> (3) *Prohibited Affiliations with Individuals Debarred by Federal Agencies*
> The following individuals are covered under this Section:
> (a) Providers – All contracted providers
> (b) Provider employees – Directors, officers, partners, agents, all employees, and persons with beneficial ownership of more than five percent of the entity's equity
> (c) Contractor employees – Directors, officers, partners, agents, all employees, and persons with beneficial ownership of five percent or more of the entity's equity
>
> Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. An enrollee may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds may be used. DCH publishes a list of providers who are terminated, suspended, or otherwise excluded from participation in the program. The Contractor must ensure that its provider networks do not include these providers.
>
> Pursuant to Section 42 CFR 438.610, a Contractor may not knowingly have a director, officer, partner, managing employee, or person with beneficial ownership of five percent or more of the entity's equity who is currently debarred or suspended by any State or federal agency. The Contractor is also prohibited from having a contractual, employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State.
>
> The review for individuals that are debarred or suspended by any State or federal agency must be performed when the Contractor initiates employment or provider enrollment. The Contractor must have procedures for the periodic review of covered individuals to ensure that none become debarred or suspended by any state or federal agency during the course of employment or contractual relationship.
>
> To meet compliance with this subsection, the Contractor must do all of the following:

(1) *Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases.*

(2) *Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the General Services Administration's Excluded Parties List System (EPLS), the Medicare Exclusion Database (MED), and any such other databases as the Secretary of HHS may prescribe.*

(3) *(a) Consult appropriate databases to confirm identity upon enrollment and reenrollment*

(b) Check the LEIE and EPLS and any such other databases as the Secretary of HHS may prescribe, no less frequently than monthly.

(4) *Check the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List and the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR) as updates are published.*

Rationale: To better align prohibited affiliations with program integrity and disclosure requirements and include all covered entities as required by 42 CFR 455.106.

30. Disclosure of Criminal Convictions

Move language regarding criminal convictions to a separate subsection. Additionally, MI added new language to clarify Contractor requirements regarding disclosures of criminal convictions. Specifically, Section 1.022(O)(4) reads as follows:

(4) *Disclosure of Criminal Convictions*

Before entering into or renewing a provider agreement, or at any time upon written request by DCH, covered individuals (described in subsection 1.022(O)(3)(a and b), must also disclose criminal convictions related to federal healthcare programs. Within 20 working days of receipt of the disclosure, the Contractor must notify the Inspector General of HHS. The Contractor will promptly notify the Inspector General of HHS and DCH of any action it takes in respect to its provider's enrollment.

Before entering into or renewing a provider agreement, or at any time upon written request by DCH, covered individuals (described in subsection 1.022(O)(3)(c) must also disclose criminal convictions related to federal healthcare programs. Within 20 working days of receipt of the disclosure, DCH will notify the Inspector General of HHS. DCH will promptly notify the Inspector General of HHS of any action it takes with respect to the Contractor's enrollment. In accordance with section 2.155 of this Contract, DCH may refuse to enter into or renew a Contract with Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. Additionally, DCH may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under this section.

Rationale: To bring contract into full compliance with 42 CFR 455.106

31. Disclosures Required by the Contractor

Insert new subsection to describe disclosure requirements for the Contractor. Specifically, the new Section 1.022(O)(5) reads as follows

(5) Disclosures Required of Contractors

All required disclosures under this subsection must be made to DCH or CMS in the format developed by the State. Failure to provide required information may lead to sanctions including withholding of capitation payment. Because federal financial participation is not available for entities that do not comply with disclosures, DCH may withhold capitation from the Contractor for services provided during the period beginning on the day following the date the information was due to DHS and ending on the day before the date on which the information was supplied.

a. Ownership and Control of Contractor – Contractors must disclose the following information for any and all persons (individual or corporation) with an ownership or control interest in the Contractor :
   - Name and Address. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
   - The date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor.

- Tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by the Contractor in which the Contractor has a five percent or more interest.
- The name, address, date of birth, the Social Security Number of managing employee of the Contractor. For purposes of this subsection, managing employees are the following: President/Chief Executive Officer, Chief Operating Officer, Chief Financial Officer and Chief of Management Information Systems.
- Information regarding relationships to others with ownership or control interest. The Contractor must report if the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor 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 has a five 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
- Information regarding related organizations. The Contractor must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which the Contractor has an ownership or control interest.

b. Disclosures for Ownership and Control of the Contractor must be made at the following times:
   - Proposal submission in accordance with the State's procurement process.
   - Contract execution
   - Contract extension
   - Within 35 days of a change in ownership of the Contractor

c. Reporting of Business Transactions of Contractor – Within 35 days of request by DCH or CMS, the Contractor must provide information related to specific business transactions which include the following:
   - The ownership of any Subcontractor as defined in Subsection 2.070 with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request
   - Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any Subcontractor, as defined in Subsection 2.070, during the five year period ending on the date of the request.

d. Contractor must report within 20 working days to the Inspector General of HHS and DCH any adverse actions taken at any time on provider applications due to fraud, quality or integrity issues as outlined under 42 CFR § 1002.3. Contractor must have policies and procedures in place which specify that adverse actions taken during provider enrollment or at any time action is taken to limit the ability of an individual to participate in the plan for reasons of fraud, quality or integrity as found under 42 CFR § 1002.3 (b)(2) and 42 CFR § 1002.3 (b)(3) must be reported within 20 working days of taking action to the Inspector General of HHS and DCH.

Rationale: To bring contract into full compliance with 42 CFR 455.104

32. Disclosures Required by the Providers in the Contractor's Network

Insert new subsection to describe disclosure requirements for the Contractor's network providers. Specifically, the new Section 1.022(O)(6) reads as follows

(6) Disclosures Required of Contracted Providers and Fiscal Agents

a. Information on ownership and control
   Contractor must require that network providers provide the disclosures described below. All disclosures must be provided to Contractor, who will make them available to DCH. Failure to obtain required information may lead to sanctions including withholding of capitation payment. Because federal financial participation is not available for entities that do not comply with disclosures, DCH may withhold capitation from the Contractor for services provided during the period beginning on the day following the date the information was due to DHS and ending on the day before the date on which the information was supplied.

b. Ownership and Control of Network Provider (includes fiscal agent or disclosing entity on behalf of network provider)
   - Name and Address. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
   - The date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in the network provider's entity

- Tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by the network provider in which the network provider has a five percent or more interest.
- The name, address, date of birth, the Social Security Number of the agent or managing employee of the network provider's entity.
- Information regarding relationships to others with ownership or control interest. The network provider must report if the person (individual or corporation) with an ownership or control interest in the network provider's entity is related to another person with ownership or control interest in the network provider's 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 has a five 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
- Information regarding related organizations. The network provider must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which the network provider has an ownership or control interest.

c. Disclosures for Ownership and Control of the network provider (or fiscal agent or disclosing entity) must be made at the following times:
   - Application submission
   - Contract execution
   - Upon request of DCH or CMS
   - During re-credentialing/re-enrollment
   - Within 35 days of a change in ownership of the Contractor

d. Reporting of Business Transactions of Network Provider – Within 35 days of request by DCH or CMS, the network provider (or fiscal agent or disclosing entity) must provide information related to specific business transactions which include the following:
   - The ownership of any subcontractor as defined in Subsection 2.070 with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request
   - Any significant business transactions between the network provider and any wholly owned supplier, or between the network provider and any subcontractor, as defined in Subsection 2.070, during the five year period ending on the date of the request.

Rationale: To bring contract into full compliance with 42 CFR 455.104

Section Three

Section three contains revisions required in response to changes in policy as well as suggested revisions from key stakeholders to clarify and delineate contract requirements.

33. Dual Medicare-Medicaid Eligible Population

Revise excluded and voluntary population lists to show that individuals with both Medicare and Medicaid are no longer excluded, but may now voluntarily enroll in the MHPs. Specifically, in Section 1.022(A), the bullet that reads "Persons with both Medicare and Medicaid eligibility" was moved from "Medicaid Eligible Groups Excluded From Enrollment in the CHCP" bullet list to the "Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP" bullet list

Rationale: Policy change effective 11/1/11 that allows dual Medicare-Medicaid individual to enroll in MHPs and is in line with changes requested by stakeholders.

34. Enrollee Health Education

Add language to the Contract to clarify acceptable practices for health education. Specifically, added a new paragraph to 1.022(H)(2) to clarify that health plans may provide health education in provider offices:

> The Contractor may provide health education to its enrollees, including health screens, in a provider office. This education must meet all of the following criteria:
>
> d. Event and incentives must be prior approved by DCH
> e. Incentive must be delivered in separate private room
> f. No advertisement of the event may be present or distributed in the provider office
> g. Only health plan enrollees may participate

Additionally, the following changes were made to 1.022(CC). In the bulleted list in section 1.022(CC)(2), the bullet was revised to read as follows:

- Health Fairs for enrollee members as described in S**ection 1.022(CC)(3)**

Finally, the following phrase was removed from the 1.022(CC)(3)(a) "…or organized by the Contractor exclusively for the Contractor's enrollees."

Rationale: Requested by stakeholders to differentiate requirements surrounding health fair as covered under 1.022(C)(3) and health education.

35. Acceptable Marketing Locations

Revise acceptable marketing locations to specify that plans may conduct approved marketing activities in schools and daycare centers as well as community centers. Specifically, the 15th bullet under Section 1.022 (CC)(2) "Examples of Allowed and Prohibited Marketing Locations and Practices" was changed to read as follows:

- community centers, schools and daycare centers

Rationale: Requested by stakeholders to clarify that schools and daycare centers are approved locations for marketing.

36. Report Clarification

Move Quality Assurance and Performance Improvement Assessment from under Annual Consolidated Report 1.042(A)(2) and re-label as 1.042(A)(3).

Rationale: Clarify that Quality Assurance and Performance Improvement Assessment is not part of the Annual Consolidated Report due on March 1. Quality Assurance and Performance Improvement Assessment is due June 30.

37. Key Personnel

Modify Contract to replace "Cheryl Bupp" with "Kathleen Stiffler"

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **June 17, 2011**
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 4
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Cheryl Bupp (517) 241-7933 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective immediately, Section 1.062 (Price Terms) is hereby replaced in its entirety with the attached.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $214,285,714.29

Contract 071B0200018
Change Notice No. 4
Signature Block

FOR THE CONTRACTOR:	**FOR THE STATE:**
OmniCare Health Plan, Inc.	
Firm Name	Signature
	Natalie Spaniolo, Acting Director
Authorized Agent Signature	Name/Title
	DTMB-Purchasing Operations
Authorized Agent (Print or Type)	Division
Date	Date

1.062 Price Terms

A. Payment Provisions
Payment under this Contract will consist of a fixed reimbursement plan with specific monthly payments. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. DCH will also pay a maternity case rate payment to the Contractor for enrollees who give birth while enrolled in the Contractor's plan. DCH will establish actuarially sound capitation rates developed in accordance with the federal requirements for actuarial soundness. The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent capitation rate development methodology that incorporates relevant information which may include: (a) the annual financial filings of all Contractors; (b) relevant Medicaid FFS data; (c) relevant Contractor encounter data.

The price per covered member will be risk adjusted (i.e., it will vary for different categories of enrollees). For enrollees in the Temporary Assistance for Needy Families (TANF) program categories, the risk adjustment will be based on age and gender. For enrollees in the Blind and Disabled program category, Michigan will utilize the Chronic Illness and Disability Payment System (CDPS) to adjust the capitation rates paid to the Contractor. Under CDPS, diagnosis coding as reported on claim and encounter transactions are used to compute a score for each individual. Individuals with inadequate eligibility history will be excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case mix value for each Contractor based on its enrolled population. The regional rate for the Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each Contractor. The aggregate impact will be budget or rate neutral. DCH will fully re-base the risk adjustment system annually. A limited adjustment to the case mix adjusted rates will occur in the intervening six month intervals based only on Contractor enrollment shifts.

DCH will annually review changes in implemented Medicaid Policy to determine the financial impact on the CHCP. Medicaid Policy changes reviewed under this Section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in covered services, and modifications to Medicaid rates for covered services. If DCH determines that the policy changes significantly affect the overall cost to the CHCP, DCH will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

DCH will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. DCH will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment before or during the month of service. DCH will report payments to Contractors on a HIPAA-compliant 820 file. A process will be in place to ensure timely payments and to identify enrollees that the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns). DCH may initiate a process to recoup capitation payments made to the Contractor for enrollees who were retroactively disenrolled or who are granted retroactive Medicare coverage.

The application of Contract remedies and performance bonus payments as described in Sections 1.022(EE) and 1.062(B) of this Contract will affect the lump-sum payment. Payments in any given fiscal year are contingent upon and subject to federal and State appropriations.

B. Contractor Performance Bonus
During each Contract year, DCH will withhold .0019 of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

DCH will establish a separate Targeted Performance Incentive Award. Funds allocated to this award will be distributed in equal proportions to each qualifying Contractor. DCH will establish the criteria used to distribute this award to Contractors.

C. Payment Option

Contracts are full-risk. However, the State reserves the right to offer a cost settlement option for inpatient services to Contractor's whose total plan membership is less than 10,000 members. The cost settlement will be based on Medicaid fee-for-service inpatient rates in effect on the date of service. The cost settlement option will be discontinued when the Contractor's total plan membership reaches 10,000.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **December 28, 2010**
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Cheryl Bupp (517) 241-7933 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective as indicated, the attached Contract Changes for Fiscal Year 2011 are hereby incorporated into this Contract (see attachments).

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $214,285,714.29

Contract Changes for Fiscal Year 2011
Contract Changes are Effective 10/01/2010

Contract Change #1: Covered Services

As part of the budget for the Michigan Department of Community Health (MDCH) for FY2011, the Legislature mandated reinstatement of certain services for Medicaid beneficiaries. Therefore, the bullets in Section 1.022(E) addressing podiatric and vision services are changed to read as follows:

- Podiatry services
- Vision services for Enrollees 21 Years of Age and Under (Routine eye exams, eye glasses, contact lens, and other vision supplies and services as well as services relating to eye trauma and eye disease
- Vision Services for Enrollees Over 21 Years of Age (Low vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services as well as services relating to eye trauma and eye disease)

Rationale: Pursuant to Public Act 187 of 2010, the Michigan Department of Community Health (MDCH) is reinstating coverage for the Podiatry and low-vision eyeglasses and associated services for Medicaid beneficiaries age 21 years and older.

Report Date: 10/19/2010 1:32:20 PM

MHP Rates Report

Rate Effective: 10/01/2010
Plan Name: OMNICARE
Plan ID: 4618768, 4618777
Approved Counties: 82
Region##: 1

Rate Cell	Program Eligibility Group	Age	Gender	Base Rate	HRA	GME	SNAF	Adjusted Base Rate	Age/ Gender/ Region	County	OAA Factor	For Profit Status Factor	MCO Risk Adjustment Factor	Gross Capitation Rate	Withhold	Family Planning Add On	Net Rate
1	TANF	<1	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.3948	0.9908	1.000	1.007	1.0000	$540.75	$1.03	$0.00	$539.72
2	TANF	<1	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.2074	0.9908	1.000	1.007	1.0000	$510.90	$0.97	$0.00	$509.93
3	TANF	1-4	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.6819	0.9908	1.000	1.007	1.0000	$108.62	$0.21	$0.00	$108.41
4	TANF	1-4	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.5780	0.9908	1.000	1.007	1.0000	$92.07	$0.17	$0.00	$91.90
5	TANF	5-14	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.4946	0.9908	1.000	1.007	1.0000	$78.78	$0.15	$0.00	$78.63
6	TANF	5-14	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.4555	0.9908	1.000	1.007	1.0000	$72.56	$0.14	$0.00	$72.42
7	TANF	15-20	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.5766	0.9908	1.000	1.007	1.0000	$91.85	$0.17	$0.00	$91.68
8	TANF	15-20	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.8980	0.9908	1.000	1.007	1.0000	$143.04	$0.27	$4.58	$147.35
9	TANF	21-25	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.8974	0.9908	1.000	1.007	1.0000	$142.95	$0.27	$0.00	$142.68
10	TANF	21-25	Female	$120.96	$25.70	$2.95	$10.04	$159.65	1.5447	0.9908	1.000	1.007	1.0000	$246.05	$0.47	$14.67	$260.25
11	TANF	26-39	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	0.9908	1.000	1.007	1.0000	$269.85	$0.51	$0.00	$269.34
12	TANF	26-39	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	0.9908	1.000	1.007	1.0000	$323.31	$0.61	$8.78	$331.48
13	TANF	40-44	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	0.9908	1.000	1.007	1.0000	$269.85	$0.51	$0.00	$269.34
14	TANF	40-44	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	0.9908	1.000	1.007	1.0000	$323.31	$0.61	$8.78	$331.48
15	TANF	45-64	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	0.9908	1.000	1.007	1.0000	$552.64	$1.05	$0.00	$551.59
16	TANF	45-64	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	0.9908	1.000	1.007	1.0000	$538.33	$1.02	$0.00	$537.31
17	TANF	65+	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	0.9908	1.000	1.007	1.0000	$552.64	$1.05	$0.00	$551.59
18	TANF	65+	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	0.9908	1.000	1.007	1.0000	$538.33	$1.02	$0.00	$537.31
19	ABAD	<1	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
20	ABAD	<1	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
21	ABAD	1-4	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
22	ABAD	1-4	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
23	ABAD	5-14	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
24	ABAD	5-14	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
25	ABAD	15-20	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
26	ABAD	15-20	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
27	ABAD	21-25	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
28	ABAD	21-25	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
29	ABAD	26-39	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
30	ABAD	26-39	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
31	ABAD	40-44	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
32	ABAD	40-44	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
33	ABAD	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
34	ABAD	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
35	ABAD	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
36	ABAD	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9761	$919.71	$1.75	$1.52	$919.48
37	OAA	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9761	$698.29	$1.33	$0.00	$696.96
38	OAA	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9761	$698.29	$1.33	$0.00	$696.96
39	OAA	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9761	$698.29	$1.33	$0.00	$696.96
40	OAA	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9761	$698.29	$1.33	$0.00	$696.96
41	MCR			$4,292.73	$1,826.20	$388.59		$6,507.52		1.0426		1.007		$6,832.23	$12.98	$0.00	$6,819.25

Rate Effective: 10/01/2010
Plan Name: OMNICARE
Plan ID: 4618768, 4618777
Approved Counties: 63
Region##: 10

Rate Cell	Program Eligibility Group	Age	Gender	Base Rate	HRA	GME	SNAF	Adjusted Base Rate	Age/ Gender/ Region	County	OAA Factor	For Profit Status Factor	MCO Risk Adjustment Factor	Gross Capitation Rate	Withhold	Family Planning Add On	Net Rate
1	TANF	<1	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.3948	1.0370	1.000	1.007	1.0000	$565.97	$1.08	$0.00	$564.89
2	TANF	<1	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.2074	1.0370	1.000	1.007	1.0000	$534.72	$1.02	$0.00	$533.70
3	TANF	1-4	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.6819	1.0370	1.000	1.007	1.0000	$113.68	$0.22	$0.00	$113.46
4	TANF	1-4	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.5780	1.0370	1.000	1.007	1.0000	$96.36	$0.18	$0.00	$96.18
5	TANF	5-14	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.4946	1.0370	1.000	1.007	1.0000	$82.46	$0.16	$0.00	$82.30
6	TANF	5-14	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.4555	1.0370	1.000	1.007	1.0000	$75.94	$0.14	$0.00	$75.80
7	TANF	15-20	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.5766	1.0370	1.000	1.007	1.0000	$96.13	$0.18	$0.00	$95.95
8	TANF	15-20	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.8980	1.0370	1.000	1.007	1.0000	$149.71	$0.28	$4.58	$154.01
9	TANF	21-25	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.8974	1.0370	1.000	1.007	1.0000	$149.61	$0.28	$0.00	$149.33
10	TANF	21-25	Female	$120.96	$25.70	$2.95	$10.04	$159.65	1.5447	1.0370	1.000	1.007	1.0000	$257.53	$0.49	$14.67	$271.71
11	TANF	26-39	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	1.0370	1.000	1.007	1.0000	$282.43	$0.54	$0.00	$281.89
12	TANF	26-39	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	1.0370	1.000	1.007	1.0000	$338.38	$0.64	$8.78	$346.52
13	TANF	40-44	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	1.0370	1.000	1.007	1.0000	$282.43	$0.54	$0.00	$281.89
14	TANF	40-44	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	1.0370	1.000	1.007	1.0000	$338.38	$0.64	$8.78	$346.52
15	TANF	45-64	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	1.0370	1.000	1.007	1.0000	$578.40	$1.10	$0.00	$577.30
16	TANF	45-64	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	1.0370	1.000	1.007	1.0000	$563.43	$1.07	$0.00	$562.36
17	TANF	65+	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	1.0370	1.000	1.007	1.0000	$578.40	$1.10	$0.00	$577.30
18	TANF	65+	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	1.0370	1.000	1.007	1.0000	$563.43	$1.07	$0.00	$562.36
19	ABAD	<1	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
20	ABAD	<1	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
21	ABAD	1-4	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
22	ABAD	1-4	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
23	ABAD	5-14	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
24	ABAD	5-14	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
25	ABAD	15-20	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
26	ABAD	15-20	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
27	ABAD	21-25	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
28	ABAD	21-25	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
29	ABAD	26-39	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
30	ABAD	26-39	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
31	ABAD	40-44	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
32	ABAD	40-44	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
33	ABAD	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
34	ABAD	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
35	ABAD	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
36	ABAD	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0906	1.000	1.007	0.9909	$933.66	$1.77	$1.52	$933.41
37	OAA	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9909	$708.88	$1.35	$0.00	$707.53
38	OAA	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9909	$708.88	$1.35	$0.00	$707.53
39	OAA	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9909	$708.88	$1.35	$0.00	$707.53
40	OAA	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0924	0.758	1.007	0.9909	$708.88	$1.35	$0.00	$707.53
41	MCR			$4,292.73	$1,826.20	$388.59		$6,507.52		0.9773		1.007		$6,404.32	$12.17	$0.00	$6,392.15

Rate Effective: 10/01/2010
Plan Name: OMNICARE
Plan ID: 4618768, 4618777
Approved Counties: 99
Region##: 99

Rate Cell	Program Eligibility Group	Age	Gender	Base Rate	HRA	GME	SNAF	Adjusted Base Rate	Age/ Gender/ Region	County	OAA Factor	For Profit Status Factor	MCO Risk Adjustment Factor	Gross Capitation Rate	Withhold	Family Planning Add On	Net Rate
1	TANF	<1	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.3948	1.0000	1.000	1.007	1.0000	$545.77	$1.04	$0.00	$544.73
2	TANF	<1	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.2074	1.0000	1.000	1.007	1.0000	$515.65	$0.98	$0.00	$514.67
3	TANF	1-4	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.6819	1.0000	1.000	1.007	1.0000	$109.63	$0.21	$0.00	$109.42
4	TANF	1-4	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.5780	1.0000	1.000	1.007	1.0000	$92.92	$0.18	$0.00	$92.74
5	TANF	5-14	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.4946	1.0000	1.000	1.007	1.0000	$79.52	$0.15	$0.00	$79.37
6	TANF	5-14	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.4555	1.0000	1.000	1.007	1.0000	$73.23	$0.14	$0.00	$73.09
7	TANF	15-20	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.5766	1.0000	1.000	1.007	1.0000	$92.70	$0.18	$0.00	$92.52
8	TANF	15-20	Female	$120.96	$25.70	$2.95	$10.04	$159.65	0.8980	1.0000	1.000	1.007	1.0000	$144.37	$0.27	$4.58	$148.68
9	TANF	21-25	Male	$120.96	$25.70	$2.95	$10.04	$159.65	0.8974	1.0000	1.000	1.007	1.0000	$144.27	$0.27	$0.00	$144.00
10	TANF	21-25	Female	$120.96	$25.70	$2.95	$10.04	$159.65	1.5447	1.0000	1.000	1.007	1.0000	$248.34	$0.47	$14.67	$262.54
11	TANF	26-39	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	1.0000	1.000	1.007	1.0000	$272.36	$0.52	$0.00	$271.84
12	TANF	26-39	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	1.0000	1.000	1.007	1.0000	$326.31	$0.62	$8.78	$334.47
13	TANF	40-44	Male	$120.96	$25.70	$2.95	$10.04	$159.65	1.6941	1.0000	1.000	1.007	1.0000	$272.36	$0.52	$0.00	$271.84
14	TANF	40-44	Female	$120.96	$25.70	$2.95	$10.04	$159.65	2.0297	1.0000	1.000	1.007	1.0000	$326.31	$0.62	$8.78	$334.47
15	TANF	45-64	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	1.0000	1.000	1.007	1.0000	$557.77	$1.06	$0.00	$556.71
16	TANF	45-64	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	1.0000	1.000	1.007	1.0000	$543.33	$1.03	$0.00	$542.30
17	TANF	65+	Male	$120.96	$25.70	$2.95	$10.04	$159.65	3.4694	1.0000	1.000	1.007	1.0000	$557.77	$1.06	$0.00	$556.71
18	TANF	65+	Female	$120.96	$25.70	$2.95	$10.04	$159.65	3.3796	1.0000	1.000	1.007	1.0000	$543.33	$1.03	$0.00	$542.30
19	ABAD	<1	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
20	ABAD	<1	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
21	ABAD	1-4	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
22	ABAD	1-4	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
23	ABAD	5-14	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
24	ABAD	5-14	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
25	ABAD	15-20	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
26	ABAD	15-20	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
27	ABAD	21-25	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
28	ABAD	21-25	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
29	ABAD	26-39	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
30	ABAD	26-39	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
31	ABAD	40-44	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
32	ABAD	40-44	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
33	ABAD	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
34	ABAD	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
35	ABAD	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
36	ABAD	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	1.000	1.007	1.0000	$863.96	$1.64	$1.48	$863.80
37	OAA	45-64	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	0.803	1.007	1.0000	$693.76	$1.32	$0.00	$692.44
38	OAA	45-64	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	0.803	1.007	1.0000	$693.76	$1.32	$0.00	$692.44
39	OAA	65+	Male	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	0.803	1.007	1.0000	$693.76	$1.32	$0.00	$692.44
40	OAA	65+	Female	$643.44	$168.91	$25.52	$20.08	$857.95	1.0000	1.0000	0.803	1.007	1.0000	$693.76	$1.32	$0.00	$692.44
41	MCR			$4,292.73	$1,826.20	$388.59		$6,507.52		1.0000		1.007		$6,553.07	$12.45	$0.00	$6,540.62

MEDICAID MANAGED CARE
Medicaid Health Plans
(Contract Year October 1, 2010 – September 30, 2011)

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE)**.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the calendar year.	≥84% Combination 2	HEDIS report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥87%	HEDIS report	Annual
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥67%	HEDIS report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥80% continuous enrollment	MDCH Data Warehouse	Monthly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥65%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 57%	Encounter data	Quarterly
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥71%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 65%	Encounter data	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Customer Services:** Enrollee Complaints ▪	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < .25 per 1000 member months	Customer Relations Management (CRM)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, and ≤1.50% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Complete submission	MI Enrolls	Monthly

Health Plan Name	FY 11 Performance Bonus Template		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2011 HEDIS	2011 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds- Ages 5-11		0	0.0%	0.0%	0.0%
Adult BMI		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Other					
Children BMI					
Childhood - Combo 3		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2011 HEDIS	2011 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%
7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	Last CAHPS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%**	75%**	90%**
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%
Advising Smokers and Tobacco Users to Quit		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	Last CAHPS Score	50% (1 point); 75% (2 points); 90% (3 points)	50%	75%	90%
Discussing Cessation Medications		0	0.0%	0.0%	0.0%
Discussing Cessation Strategies		0	0.0%	0.0%	0.0%

Accreditation Status - 2010	Accredited or Conditional as of 12/31/10 (7 pts)	NCQA New Plan or URAC Provisional Accreditation as of 12/31/10 (8.5 points)	Excellent/ Commendable or Full Accreditation as of 12/31/10 (10 Pts)
Org Name (Date of visit)			
Total Member Months of Enrollment by Age and Sex - HEDIS 2010	0		

Summary	Possible Points	Health Plan Points	DCH Focus (Total 40 Pt.)	Score	Incentive Points
Clinical Measures (42.0%)	68	0.0	**ABCD 20 pts**	0.0%	0.0
Access to Care (15.0%)	24	0.0	**E-prescribing 20 pts**	0.0%	0.0
Survey Measures (CAHPS) (13.0%)	22	0.0	Total Points		
Accreditation Status (6.0%)	10	0.0			
DCH Focus Study Requirements (24.0%)	40	0.0	CAHPS Survey Measures		

Performance Bonus Total Score	164	0.0	** based on 2010 NCQA Quality Compass.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET September 14, 2010
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **OmniCare Health Plan, Inc.** **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	TELEPHONE (313) 465-1519 **Beverly Allen** BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Cheryl Bupp (517) 241-7933 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective as indicated, the attached Contract Changes for Fiscal Year 2011 are hereby incorporated into this Contract (see attachments).

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $214,285,714.29

Contract Changes for Fiscal Year 2011
Contract Changes are Effective 10/01/2010

Contract Change #1: EHR

Modify the definition section to include the acronym "EHR". Specifically, the definition EHR reads as follows:

> **Electronic health record**

Rationale: The acronym "EHR" is used in the contract; therefore, the acronym must be defined.

Contract Change #2: Reference to Number of Beneficiaries

Modify 1.022(A) to remove reference to specific number of beneficiaries. Specifically, the first sentence of 1.022(A) is modified as follows:

> The Michigan Medicaid program arranges for and administers medical assistance to ~~approximately 1.4 million~~ beneficiaries **who meet the requirements for Medicaid assistance as defined in policy.**

Rationale: The specific number of beneficiaries may change significantly over the course of the contract. By removing reference to the number of beneficiaries, DCH and the MHPs are not required to effectuate a contract change when the number of beneficiaries increases or decreases.

Contract Change #3: Mandatory Populations

Modify 1.022(A) to indicate that foster care children are moved from an excluded population to a mandatory population. Specifically, modify the two bulleted lists in section 1.022. The lists will read as follows:

Medicaid Eligible Groups Who Must Enroll in the CHCP:

- **Children in foster care**
- Families with children receiving assistance under the Financial Independence Program (FIP)
- Persons under age 21 who are receiving Medicaid
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged
- Pregnant women

Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:

- Migrants
- Native Americans

Medicaid Eligible Groups Excluded From Enrollment in the CHCP:

* Persons without full Medicaid coverage
* Persons with Medicaid who reside in an Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or a State psychiatric hospital
* Persons receiving long term care (custodial care) in a licensed nursing facility
* Persons being served under the Home & Community Based Elderly Waiver
* Persons enrolled in Children's Special Health Care Services (CSHCS)
* Persons with commercial HMO coverage, including Medicare HMO coverage

* Persons in PACE (Program for All-inclusive Care for the Elderly)
* Deductible clients (also known as Spenddown)
* Children in ~~foster care or in~~ Child Care Institutions
* Persons in the Refugee Assistance Program
* Persons in the Repatriate Assistance Program
* Persons in the Traumatic Brain Injury program
* Persons with both Medicare and Medicaid eligibility
* Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
* Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan
* Persons incarcerated in a city, county, State, or federal correctional facility

Rationale: Effective 10/01/2010, Foster Care Children with specific service living arrangement codes will be a mandatory population for enrollment in the MHPs.

Contract Change #4: Enrollment Date

Modify 1.022(A)(6) to clarify that while enrollment is usually on a calendar month basis, DCH may choose to disenroll a beneficiary in the middle of the month. Specifically, the first sentence of 1.022(A)(6) is modified as follows:

(6) Enrollment Date
Any changes in enrollment will be approved and implemented by DCH on a calendar month basis **unless the Contractor is notified of a mid-month disenrollment on the weekly enrollment file.**

Rationale: According to Medicaid Policy, a change in an enrollee's status may require DCH to disenroll the enrollee from the MHP in the middle of the month rather than at the end of a service month (e.g. incarceration, placement in Child Care Institution, or special disenrollment due to violent or life threatening behavior). This is a clarification of policy **not** a policy change.

Contract Change #5: Mental Health Services

Modify 1.022(E) and 1.022(F)(16) to clarify that MHPs must provide mental health services to enrollees with mild to moderate mental illness in accordance with Medicaid policy. Specifically, the bullet addressing mental health services in the list of covered services (21st bullet) is changed to read as follows:

- Mental health care – maximum of 20 outpatient visits per calendar year **in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility section.**

Rationale: Medicaid policy contains specific language regarding the types of persons and services covered under the CHCP and the types of persons and services covered under the 1915(c) mental health waiver. This contract change is designed to clarify that the MHPs' coverage policies for mental health must align with Medicaid policy; this is **not** a policy change.

Contract Change #6: Member Handbook

Modify 1.022(H) to require that MHPs provide co-payment information to enrollees in the plan's member handbook. Specifically, a new roman numeral "v" will be added to the alphabetized list in 1.022(H)(3) that reads as follows; all other numbers will be revised as necessary:

v. Description of co-payment requirements

Rationale: Section 438.10(f)(6) of the Balanced Budget Act (42 CFR 438 Subpart A) requires that MCOs provide certain information to enrollees at the time of enrollment. Subsection 438.10(f)(6)(xi) lists cost sharing as one element that MCOs must address. DCH has determined that the member handbook is the appropriate avenue for disseminating co-payment information to enrollees.

Contract Change #7: Health Information Technology

Modify 1.022(P) to include information on Health Information Technology requirements. Specifically, add a new section 1.022(P(5) that reads as follows:

> **The Contractor must comply with MDCH performance programs and contract requirements designed to advance provider adoption and meaningful use of certified health information technology (HIT). MDCH is implementing the Medicaid Electronic Health Record (EHR) incentive program pursuant to the final rule on meaningful use of EHRs under the Medicare and Medicaid EHR incentive programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH). Contractors are encouraged to utilize these rules as guidelines when designing and establishing HIT programs and processes.**
>
> **Contractors must engage in activities that further MDCH's goal that Medicaid eligible professionals and hospitals become Stage I meaningful users. At a minimum, the Contractor should perform the following activities:**
>
> - **Assist MDCH in statewide efforts to target high volume Medicaid providers that may be eligible for the EHR incentive payments**
> - **Align provider incentives with meaningful use measures**
> - **Promote the EHR Incentive program as part of regular provider communications**
> - **Exchange eligibility and claim information electronically to promote the use of electronic health records**

Rationale: For successful implementation of the EHR incentive program, MDCH needs MHPs to encourage and support MDCH efforts to advance provider adoption and meaningful use of certified health information technology (HIT). MHP support is required, in conjunction with efforts being conducted at MDCH, to ensure that the Medicaid eligible professionals and hospitals become Stage I meaningful users.

Contract Change #8: MIHP Services

Modify 1.022(R) to remove the reference to MIHP services. Specifically, revise 1.022(R)(2)(f) to read as follows:

> (f) Provides access to ancillary services such as pharmacy services, durable medical equipment services, home health services ~~and MIHP services~~.

Rationale: MIHP services are provided through MDCH fee-for-service; the MHP is not responsible for provided MIHP services.

Contract Change #9: Co-payments

Modify 1.022(U) to remove the reference to DCH approval of co-payment requirements. Specifically, revise 1.022(U)(1)(a) to read as follows:

(a) Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles can be collected from enrollees. ~~Co-payments are only permitted with DCH approval.~~

Rationale: The contract requirement in 1.022(U) does not relate to DCH approval of co-payment requirements. DCH approval of co-payment requirements is addressed in 1.022(Y)(5).

Contract Change #10: Annual Compliance Review

Modify 1.022(DD) to update the terminology of the Annual Compliance Review. Specifically, the first two paragraphs of 1.022 (DD) are revised to read as follows:

DD Contractor ~~On-Site~~ **Compliance** Reviews
Contractor ~~on-site~~ **compliance** reviews by DCH will be an ongoing activity conducted during the Contract. The Contractor's ~~on-site~~ **compliance** review will include a desk audit and on-site focus component. The ~~site~~ **compliance** review will focus on specific areas of health plan performance. These focus areas may include, but are not limited to the following:

* Administrative capabilities
* Governing body
* Subcontracts
* Provider network capacity and services
* Provider appeals
* Member services
* Primary care provider assignments and changes
* Enrollee grievances and appeals
* Health education and promotion
* Quality improvement
* Utilization review
* Data reporting
* Coordination of care with the CMHSP and PIHP providers
* Claims processing
* Fraud and abuse

DCH will determine if the Contractor meets contractual requirements and assess health plan compliance. Deemed status ~~is~~ **may be granted** when a DCH approved accrediting agency has reviewed the criteria and determined that the plan meets the criteria. DCH reserves the right to conduct a comprehensive ~~onsite~~ **compliance** review ~~utilizing the site review tool.~~

Rationale: DCH updated the terminology of the annual compliance review to better match federal requirements and more clearly indicate the nature of the annual compliance review. DCH is not changing the structure of the compliance review.

Contract Change #11: Administrative Personnel

Modify 1.031(C) to add specific administrative personnel requirements for privacy and security functions. Specifically, the following two additional requirements are added to the end of 1.031(C)

(12) Privacy Officer
The Contractor must provide a Privacy Officer who is responsible for the development and implementation of privacy policies and procedures outlined in 45 CFR 164. The Privacy Officer must also be designated as the individual to receive complaints pursuant to breaches of the Contractor's privacy policies and procedures

(13) Security Officer
The Contractor must provide a Security Officer who is responsible for the development and implementation of security policies and procedures outlined in 45 CFR 164. The Security Officer must also be designated as the individual to receive complaints pursuant to breaches of the Contractor's security policies and procedures

Rationale: Title 45 of Code of Federal Regulations, Sections 164.530 and 164.308 require covered entities to appoint a privacy and security official, respectively. DCH determined these positions are critical to the continued compliance of MHPs with federal laws; therefore, DCH decided these positions should be included in required personnel specified in the Contract. As such, the Contractor must provide written notification to DCH of any vacancies or staffing changes within 30 days and fill any vacancies within 6 months.

Contract Change #12: Encounter Data

Modify 1.042 to add certain reporting requirements for encounter data. Specifically, the following sentence is added to the beginning of the second paragraph of 1.042(A)(5):

Contractors must populate all fields required by DCH including, but not limited to, financial data for all encounters and fields required for the MCO pharmacy rebate.

Rationale: With the passage of Affordable Care Act (Patient Protection and Affordable Care Act), CMS will allow States to collect rebates on drugs provided by MCOs (managed care organizations). Therefore, DCH must require MHPs to provide all relevant data, including financial data, needed to accurately file rebate requests.

Contract No. 071B0200018
Change Notice No. 2
Signature Page

FOR THE CONTRACTOR:	**FOR THE STATE:**
OmniCare Health Plan, Inc.	
Firm Name	Signature
	Sergio Paneque, Director
Authorized Agent Signature	Name/Title
	Business Services Administration
Authorized Agent (Print or Type)	Division
Date	Date

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

April 15, 2010

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Cheryl Bupp (517) 241-7933 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective as indicated, the attached Contract Changes for Fiscal Year 2010 are hereby incorporated into this Contract (see attachments).

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $214,285,714.29

FOR THE CONTRACTOR:	**FOR THE STATE:**
OmniCare Health Plan, Inc. Firm Name	Signature
Authorized Agent Signature	**Sergio Paneque, Director** Name/Title
Authorized Agent (Print or Type)	**Business Services Administration** Division

Date

Date

Contract Changes for Fiscal Year 2010
Contract Changes # 1 through #16 are effective 10/01/2009
Contract Change #17 is effective 03/01/2010 and change #18 is effective 4/01/2010

Contract Change #1: Newborn Enrollment

Modify 1.022(A)(7) to clarify that Medicaid Health Plans (MHPs) must submit newborn enrollment service requests via Siebel within 90 days of the birth. Only newborn service requests received by this deadline will generate a retroactive newborn enrollment effective for birth month and applicable retroactive months. Specifically, the second paragraph of 1.022(A)(7) is modified to read as follows:

> If DCH does not notify the Contractor of the newborn's enrollment within two months of the birth or the child is born outside Michigan, the Contractor is responsible for submitting a newborn ~~notification form~~ service request to DCH. The Contractor must submit the newborn ~~notification form~~ service request to DCH within 90 days of the date of birth. ~~or 30 days of notification of the birth, whichever is later.~~ If the Contractor submits the newborn ~~notification form~~ service request after the deadline, the child will be enrolled retroactively for the birth month only. **DCH will not accept requests for newborn enrollment from the Contractor after six months from date of birth.** (emphasis in original)

Rationale: DCH expects plans to track pregnant enrollees to ensure that the woman is receiving all required pre-natal care to facilitate a positive birth outcome. Therefore, MHPs should be aware of all newborns within 90 days of birth. Further, the Enrollment Services Section (ESS) that processes the newborn enrollment service requests cannot accurately track when the MHP was notified of the birth. ESS must use the 90-day deadline to decide when a newborn should be enrolled retroactively for all months or for birth month only. This contract change also updates language to show that MHPs are required to request newborn enrollment using an electronic Siebel service request rather than a paper notification form.

Contract Change #2: Re-enrollment

Modify 1.022(A)(8) to change the period of re-enrollment from three months to two months. Specifically, 1.022(A)(8) is modified to read as follows:

> Enrollees who are disenrolled from the Contractor's plan due to loss of Medicaid eligibility or DHS action will be automatically re-enrolled prospectively to the same Contractor provided that they regain eligibility within ~~three~~ **two** months.

Rationale: 42 CFR 438.56(g) requires that the contract may allow for automatic reenrollment of a beneficiary who has lost Medicaid eligibility for a period of two months or less. In the most recent site visit, CMS clarified that the contract language must specifically state this requirement.

Contract Change #3: Covered Services

Executive Order 2009-22 and the pursuant MSA Bulletin 09-28 require the removal of the following services as covered services under the contract for individuals 21 years of age and older:

1. Chiropractic Services – No services provided by a Chiropractor are covered.
2. Podiatrist Services – No services provided by a Podiatrist are covered.
3. Hearing Aid Dealers – No hearing aids are covered.
4. Eye Glasses and Associated Vision Services – Routine eye exams, eye glasses, contact lens, and other vision supplies and services are not covered. Services relating to eye trauma and eye disease continue to be covered.

5. Dental Services – The adult dental benefit is limited to specific emergent/urgent services for the relief of pain and/or infection only. These emergent/urgent services are covered for enrollees age 21 and older (including nursing facility residents). Routine examinations, prophylaxis, restorations, and dentures are not covered.

Accordingly, the following bullets from the bulleted list in 1.022(E)(1) are modified as follows:

- Chiropractic services **(only for enrollees under 21 years of age)**
- Hearing aids **(only for enrollees under 21 years of age)**
- Podiatry services **(only for enrollees under 21 years of age)**
- Vision services **(for enrollees 21 years of age and older only services relating to eye trauma and eye disease are covered; Routine eye exams, eye glasses, contact lens, and other vision supplies and services as well as services relating to eye trauma and eye disease are covered for enrollees under 21 years of age)**

Rationale: Due to Michigan's financial crisis, the Governor removed coverage for specific services that are not federally mandated for adults under the Medicaid program.

Contract Change #4: Compliance Committee

Modify 1.022(O)(1)(b) to specify that MHPs must establish and maintain a compliance committee in addition to specifying a compliance officer. Specifically, 1.022(O)(1)(b) is modified to read as follows:

(b) The designation of a compliance officer **and a compliance committee** who is accountable to the senior management or Board of Directors and who has effective lines of communication to the Contractor's employees

Rationale: Federal law has not removed the requirement that managed care organizations establish and maintain a compliance committee as part of the plan's compliance and integrity program. This phrase was inadvertently deleted from the contract.

Contract Change #5: Review for Fraud, Waste and Abuse

Clarify requirements regarding review of provider records for evidence of fraud, waste and abuse. Specifically eliminate section 1.022(V)(1)(c) in entirety and re-number the remaining subsections. The subsection deleted read as follows:

~~Review the provider's record for fraud, waste, and abuse~~.;

Rationale: At the time of credentialing and recredentialing, DCH requires that health plans review the provider actions and the health plan's documentation regarding the provider for evidence of fraud, waste and abuse. DCH does not require MHPs to review the provider's patient medical records.

Contract Change #6: Payment Option

Clarify the rates to be utilized for any cost settlement done under 1.062(C) of the contract. Specifically 1.062(C) is revised to read as follows:

Contracts are full-risk. However, the State reserves the right to offer a cost settlement option for inpatient services to Contractor's whose total plan membership is less than 10,000 members. **The cost settlement will be based on Medicaid fee-for-service inpatient rates in effect on the date of service.** The cost settlement option will be discontinued when the Contractor's total plan membership reaches 10,000.

Rationale: This contract change is needed to clarify the rates that DCH will use in calculating cost settlements with MHPs who qualify for this payment option.

Contract Change #7: Withhold Amount

Modify the amount of the rate withheld from each capitation payment used to fund the Annual Performance Bonus Program and the Targeted Performance Incentive Award. Specifically, the first sentence of 1.062(B) is modified to read as follows:

> During each Contract year, DCH will withhold ~~.0050~~ **.0019** of the approved capitation payment from each Contractor.

Rationale: Ordered by Section 1815 of PA 131 of 2009

Contract Change #8: Performance Monitoring

An updated Appendix 4 is included in these contract changes.

Contract Change #9: Service Area

DCH will send each plan a revised Attachment A that reflects the service area in effect as of October 1, 2009.

Contract Change #10: Contracted Rates

DCH will send each plan a revised Attachment B that reflects the rates in effect as of October 1, 2009 for fiscal year 2010.

Contract Change #11: Disenrollment Without Cause

CMS directed DCH to include language in the MHP contract that states an enrollee may request disenrollment without cause if the enrollee missed open enrollment due to eligibility. Section 42 CFR 438.56 requires that the State allow enrollees to disenroll without cause if the enrollee was temporarily ineligible for Medicaid during open enrollment. Specifically, a new section, 1.022(C)(3) is added and reads as follows:

> **(3) Open Enrollment Opportunity Not Available**
> **The enrollee may request a disenrollment from his or her current MHP if the enrollee missed the opportunity to change health plans during the most recent open enrollment period due to a temporary loss of Medicaid eligibility. If the enrollee is a mandatory enrollee in a county with two available MHPs, the enrollee must choose another MHP in which to enroll; the enrollee may not return to fee-for-service Medicaid. The beneficiary must submit a request to DCH.**

Rationale: This contract change was requested by the CMS.

Contract Change #12: I/T/U

Section 5006 of The American Recovery and Reinvestment Act delineates specific requirements for managed care entities with regard to enrollees' use of Indian Health Services/Tribal Health Centers/Urban Indian Organizations (I/T/Us). The Act requires manage care entities to allow enrollees who are Native American to have access to these type service providers. To incorporate these requirements, DCH added a paragraph to Section 1.022(F)(4) that reads as follows:

If an I/T/U provider is contracted with the MHP, Native Americans who enrolled in the plan must be allowed to choose the I/T/U provider as their PCP. If the I/T/U is not contracted with the MHP, Native Americans must still be allowed to use the provider without authorization. I/T/U providers are entitled, pursuant to the ARRA 5006, to be paid for covered Medicaid services at the same payment that would be made if the provider were a non-I/T/U participating provider. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903(m) organizations (health plans) and the amount they would receive per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

Rationale: This contract change was requested by the CMS.

Contract Change #13: Member handbooks

CMS requires that DCH include the Balanced Budget Act reference to member handbook requirements in the MHP contract. Therefore, DCH modified the first sentence of the second paragraph of 1.022(H)(3)(b) to read as follows:

> At a minimum, the member handbook must include the following information **as specified in 42 CFR 438.10(f)(2)**:

Rationale: This contract change was requested by the CMS.

Contract Change #14: Provider Directory

Under direction from Center for Medicaid and Medicare Services (CMS), DCH must clarify how MHPs provide the provider directory to enrollees. CMS has determined that the language "make available" is not equivalent to "provide." Therefore, DCH is modifying the provider directory requirements to indicate that the MHP must provide the provider directory to the enrollee utilizing the web site or mailing to the enrollee. Specifically, the first paragraph of Section 1.022(H)(3)(c) is modified to read as follows:

> The Contractor must maintain a complete provider directory ~~on the Contractor's web site~~; ~~the Contractor is not required to a mail provider directory to all new enrollees.~~ The ~~web~~ provider directory must be reviewed for accuracy ~~and updated~~ at least monthly; **the web version of the provider directory must also be updated at least monthly. The Contractor must provide the provider directory in a manner agreeable to the member either by mail or** ~~inform new enrollees that the provider directory is available upon request and~~ **by utilizing** the Contractor's web site. ~~and must mail the provider directory within five business days of the enrollee's request.~~

Rationale: This contract change was requested by the CMS.

Contract Change #15: Maternal Infant Health Program (MIHP) Providers

Modify the contract to clarify the inclusion of infant services. Specifically, the final paragraph of 1.022(W)(2) is modified to read as follows:

> The Contractor must refer all ~~pregnant~~ **MIHP-eligible enrollees** for MIHP screening and coordinate care with MIHP providers. The Contractor must present evidence of referrals and care coordination to DCH upon request.

Rationale: DCH has completed development of infant services under the new MIHP program and needs to clarify that MIHP services encompass both services for pregnant women and infants.

Contract Change #16: Examination of Records

CMS requested that DCH add the specific requirement that records be made available to the federal entities as well as to the State. Specifically, Sections 2.112 and 2.113 are modified to read as follows:

> **2.112 Examination of Records**
> For seven years after the Contractor provides any work under this Contract (the "Audit Period"), the State **and/or federal representatives** may examine and copy any of Contractor's books, records, documents and papers pertinent to establishing Contractor's compliance with the Contract and with applicable laws and rules. The State **and/or federal representatives** must notify the Contractor 20 days before examining the Contractor's books and records. The State **and/or federal representatives** does not have the right to review any information deemed confidential by the Contractor to the extent access would require the Confidential Information to become publicly available. This provision also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor, or any Subcontractor of Contractor performing services in connection with the Contract.
>
> **2.113 Retention of Records**
> Contractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Contract and to the Services, equipment, and commodities provided under the Contract) pertaining to the Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State **and/or federal representatives** at any time during the Audit Period. If an audit, litigation, or other action involving Contractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later.

Rationale: This contract change was requested by the CMS.

Contract Change #17: Newborn Enrollment

Modify 1.022(A)(7) to clarify that Medicaid Health Plans (MHPs) must submit newborn enrollment service requests via Siebel within ~~90 days~~ six months of the birth. Only newborn service requests received by this deadline will generate a retroactive newborn enrollment effective for birth month and applicable retroactive months. Specifically, the second paragraph of 1.022(A)(7) is modified to read as follows:

> If DCH does not notify the Contractor of the newborn's enrollment within two months of the birth or the child is born outside Michigan, the Contractor is responsible for submitting a newborn service request to DCH. The Contractor must submit the newborn service request to DCH within ~~90 days~~six months of the date of birth. ~~If the Contractor submits the newborn service request after the deadline, the child will be enrolled retroactively for the birth month only.~~ **DCH will not accept requests for newborn enrollment from the Contractor after six months from date of birth.** (emphasis in original)

Rationale: DCH expects plans to track pregnant enrollees to ensure that the woman is receiving all required pre-natal care to facilitate a positive birth outcome. Therefore, MHPs should be aware of all newborns at the time of, or shortly after birth. DCH expects MHPs to submit newborn requests as soon as a beneficiary ID is available or within 90 days. However, this contract change allows for continuous enrollment of the newborn even under circumstances when a health plan becomes aware of the birth after three months.

Contract Change #18: Pharmacy

Remove the category of "60/40" carve-out drugs from the benefit package covered by Medicaid Health Plans and move all psychotropic medication to a complete carve out. Specifically, revise Section 1.022(F)(7) to remove paragraph (b) that describes the "60/40" carve-out and add the psychotropic medications to the paragraph that describes the pharmacy carve out. Section 1.022(F)(7) is modified as follows:

(a) Pharmacy Carve Out

The Contractor is not responsible for: (i) anti-psychotic classes and the ~~H7Z class~~ psychotropic drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out" at www.Michigan.fhsc.com; (ii) drugs in the anti-retroviral classes, as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out at www.Michigan.fhsc.com, including protease inhibitors and reverse transcriptase inhibitors; (iii) substance abuse treatment drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out at www.Michigan.fhsc.com; These medications are reimbursed by DCH's pharmacy third party administrator (TPA) through a point-of-service reimbursement system.

As of the effective date of this contract amendment, April 1, 2010, the State will no longer reimburse the Contractor (MCO) 60% of the Medicaid fee for any medication. All covered psychotropic medications as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out" at www.Michigan.fhsc.com are reimbursed by the State or the State's pharmacy vendor under fee for service at 100%". ~~Other Psychotropic Pharmacy ServicesThe Contractor agrees to act as DCH's TPA and reimburse pharmacies for psychotropic drugs not listed in the drug classifications specified above. In the performance of this function:~~

~~i. The Contractor must follow Medicaid FFS utilization controls for Medicaid psychotropic prescriptions. The Contractor must follow Medicaid FFS policy for prior authorization on all psychotropic medications~~

~~ii. The Contractor agrees that it and its pharmacy benefit managers are precluded from billing manufacturer rebates on psychotropic drugs~~

~~iii. The Contractor agrees to provide payment files to DCH in the format and manner prescribed by DCH available at www.michigan.fhsc.com/Documents~~

~~iv. DCH agrees to use the payment files to reimburse the Contractor for 60% of the Medicaid fee according to the Medicaid pharmaceutical reimbursement policy~~

The Contractor is **still** responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for enrollees but may limit access to contracted lab and x-ray providers

Rationale: This contract change was requested by the CMS.

MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2009 – September 30, 2010)

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract **Section 1.022(EE)**.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the calendar year.	Combination 2 ≥ 82%	HEDIS report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥ 85%	HEDIS report	Annual
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥ 66%	HEDIS report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥ 77% for continuous enrollment	MDCH Data Warehouse	Monthly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 64%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 57%	Encounter data	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 70%	HEDIS report	Annual
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 65%	Encounter data	Quarterly
• **Customer Services:** Enrollee Complaints	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < .25 per 1000 member months	Customer Relations Management (CRM)	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, and ≤1.50% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Complete submission	MI Enrolls	Monthly

CONTRACT #071B0200018
OMNICARE HEALTH PLAN

ATTACHMENT A
APPROVED SERVICE AREA

Oakland #63
Wayne #82

State of Michigan Managed Care Rates FY10
Effective Date 10/1/2009
Implemented 12/1/2009 with retroactive adjustments back to 10/1/2009

Omnicare 4618768; 4618777; County 82

Region 01

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	4.0449	1.007	679.33	-1.29	0.00	678.04
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.6909	1.007	619.88	-1.18	0.00	618.70
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.7150	1.007	120.08	-0.23	0.00	119.85
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.5759	1.007	96.72	-0.18	0.00	96.54
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.4539	1.007	76.23	-0.14	0.00	76.09
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.3965	1.007	66.59	-0.13	0.00	66.46
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.4919	1.007	82.61	-0.16	0.00	82.45
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.6690	1.007	112.36	-0.21	4.02	116.17
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.8187	1.007	137.50	-0.26	0.00	137.24
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.2203	1.007	204.95	-0.39	13.59	218.15
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7979	1.007	301.95	-0.57	0.00	301.38
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7937	1.007	301.25	-0.57	8.18	308.86
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7979	1.007	301.95	-0.57	0.00	301.38
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7937	1.007	301.25	-0.57	8.18	308.86
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.3686	1.007	565.75	-1.07	0.00	564.68
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.4800	1.007	584.46	-1.11	0.00	583.35
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.3686	1.007	565.75	-1.07	0.00	564.68
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.4800	1.007	584.46	-1.11	0.00	583.35
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	1.0687	0.9528	0.758	1.0000	1.007	675.20	-1.28	0.00	673.92
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	1.0687	0.9528	0.758	1.0000	1.007	675.20	-1.28	0.00	673.92
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	1.0886	1.0000	1.000	1.0000	1.007	6,899.03	-13.11	0.00	6,885.92

State of Michigan Managed Care Rates FY10
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Omnicare 4618768, 4618777; County 63

Region 10

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	4.0449	1.007	697.07	-1.32	0.00	695.75
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.6909	1.007	636.06	-1.21	0.00	634.85
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.7150	1.007	123.22	-0.23	0.00	122.99
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.5759	1.007	99.25	-0.19	0.00	99.06
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.4539	1.007	78.22	-0.15	0.00	78.07
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.3965	1.007	68.33	-0.13	0.00	68.20
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.4919	1.007	84.77	-0.16	0.00	84.61
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.6690	1.007	115.29	-0.22	4.02	119.09
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.8187	1.007	141.09	-0.27	0.00	140.82
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.2203	1.007	210.30	-0.40	13.59	223.49
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7979	1.007	309.84	-0.59	0.00	309.25
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7937	1.007	309.11	-0.59	8.18	316.70
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7979	1.007	309.84	-0.59	0.00	309.25
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7937	1.007	309.11	-0.59	8.18	316.70
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.3686	1.007	580.52	-1.10	0.00	579.42
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.4800	1.007	599.71	-1.14	0.00	598.57
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.3686	1.007	580.52	-1.10	0.00	579.42
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.4800	1.007	599.71	-1.14	0.00	598.57
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	1.0687	0.9966	0.758	1.0000	1.007	706.24	-1.34	0.00	704.90
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	1.0687	0.9966	0.758	1.0000	1.007	706.24	-1.34	0.00	704.90
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	1.0845	1.0000	1.000	1.0000	1.007	6,873.05	-13.06	0.00	6,859.99

State of Michigan Managed Care Rates FY10
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Omnicare 4618768; 4618777; County 99

Region SW

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.9369	1.007	667.04	-1.27	0.00	665.77
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.5658	1.007	604.16	-1.15	0.00	603.01
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.6918	1.007	117.21	-0.22	0.00	116.99
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5779	1.007	97.91	-0.19	0.00	97.72
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5033	1.007	85.27	-0.16	0.00	85.11
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.3955	1.007	67.01	-0.13	0.00	66.88
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5559	1.007	94.19	-0.18	0.00	94.01
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.8211	1.007	139.12	-0.26	4.42	143.28
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.8416	1.007	142.59	-0.27	0.00	142.32
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.3995	1.007	237.12	-0.45	14.18	250.85
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.9231	1.007	325.83	-0.62	0.00	325.21
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	2.0076	1.007	340.15	-0.65	8.48	347.98
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.9231	1.007	325.83	-0.62	0.00	325.21
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	2.0076	1.007	340.15	-0.65	8.48	347.98
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.4647	1.007	587.03	-1.12	0.00	585.91
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.6484	1.007	618.15	-1.17	0.00	616.98
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.4647	1.007	587.03	-1.12	0.00	585.91
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.6484	1.007	618.15	-1.17	0.00	616.98
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	0.9960	1.0000	0.821	1.0000	1.007	715.33	-1.36	0.00	713.97
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	0.9960	1.0000	0.821	1.0000	1.007	715.33	-1.36	0.00	713.97
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	0.9938	1.0000	1.000	1.0000	1.007	6,298.23	-11.97	0.00	6,286.26

State of Michigan Managed Care Rates FY10
Effective Date 1/1/2010

Omnicare 4618768; 4618777; County 82

Region 01

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	4.0449	1.007	679.33	-1.29	0.00	678.04
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.6909	1.007	619.88	-1.18	0.00	618.70
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.7150	1.007	120.08	-0.23	0.00	119.85
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.5759	1.007	96.72	-0.18	0.00	96.54
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.4539	1.007	76.23	-0.14	0.00	76.09
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.3965	1.007	66.59	-0.13	0.00	66.46
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.4919	1.007	82.61	-0.16	0.00	82.45
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.6690	1.007	112.36	-0.21	4.02	116.17
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	0.8187	1.007	137.50	-0.26	0.00	137.24
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.2203	1.007	204.95	-0.39	13.59	218.15
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7979	1.007	301.95	-0.57	0.00	301.38
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7937	1.007	301.25	-0.57	8.18	308.86
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7979	1.007	301.95	-0.57	0.00	301.38
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	1.7937	1.007	301.25	-0.57	8.18	308.86
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.3686	1.007	565.75	-1.07	0.00	564.68
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.4800	1.007	584.46	-1.11	0.00	583.35
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.3686	1.007	565.75	-1.07	0.00	564.68
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	0.9960	1.0000	1.000	3.4800	1.007	584.46	-1.11	0.00	583.35
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9528	1.000	1.0000	1.007	889.35	-1.69	1.46	889.12
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	1.0687	0.9528	0.758	1.0000	1.007	675.20	-1.28	0.00	673.92
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	1.0687	0.9528	0.758	1.0000	1.007	675.20	-1.28	0.00	673.92
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	1.0886	1.0000	1.000	1.0000	1.007	6,899.03	-13.11	0.00	6,885.92

State of Michigan Managed Care Rates FY10
Effective Date 1/1/2010

Omnicare 4618768, 4618777; County 63

Region 10

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	4.0449	1.007	697.07	-1.32	0.00	695.75
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.6909	1.007	636.06	-1.21	0.00	634.85
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.7150	1.007	123.22	-0.23	0.00	122.99
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.5759	1.007	99.25	-0.19	0.00	99.06
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.4539	1.007	78.22	-0.15	0.00	78.07
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.3965	1.007	68.33	-0.13	0.00	68.20
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.4919	1.007	84.77	-0.16	0.00	84.61
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.6690	1.007	115.29	-0.22	4.02	119.09
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	0.8187	1.007	141.09	-0.27	0.00	140.82
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.2203	1.007	210.30	-0.40	13.59	223.49
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7979	1.007	309.84	-0.59	0.00	309.25
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7937	1.007	309.11	-0.59	8.18	316.70
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7979	1.007	309.84	-0.59	0.00	309.25
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	1.7937	1.007	309.11	-0.59	8.18	316.70
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.3686	1.007	580.52	-1.10	0.00	579.42
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.4800	1.007	599.71	-1.14	0.00	598.57
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.3686	1.007	580.52	-1.10	0.00	579.42
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	1.0220	1.0000	1.000	3.4800	1.007	599.71	-1.14	0.00	598.57
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	1.0670	0.9966	1.000	1.0000	1.007	930.23	-1.77	1.46	929.92
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	1.0687	0.9966	0.758	1.0000	1.007	706.24	-1.34	0.00	704.90
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	1.0687	0.9966	0.758	1.0000	1.007	706.24	-1.34	0.00	704.90
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	1.0845	1.0000	1.000	1.0000	1.007	6,873.05	-13.06	0.00	6,859.99

State of Michigan Managed Care Rates FY10
Effective Date 1/1/2010

Omnicare 4618768; 4618777; County 99

Region SW

Rate Cell	Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Age/ Gender	For Profit	Adj Base Rate	0.19% Bonus W/H	Family Planning	Final Rate
1	TANF	<1	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.9369	1.007	667.04	-1.27	0.00	665.77
2	TANF	<1	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.5658	1.007	604.16	-1.15	0.00	603.01
3	TANF	1-4	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.6918	1.007	117.21	-0.22	0.00	116.99
4	TANF	1-4	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5779	1.007	97.91	-0.19	0.00	97.72
5	TANF	5-14	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5033	1.007	85.27	-0.16	0.00	85.11
6	TANF	5-14	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.3955	1.007	67.01	-0.13	0.00	66.88
7	TANF	15-20	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.5559	1.007	94.19	-0.18	0.00	94.01
8	TANF	15-20	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.8211	1.007	139.12	-0.26	4.42	143.28
9	TANF	21-25	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	0.8416	1.007	142.59	-0.27	0.00	142.32
10	TANF	21-25	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.3995	1.007	237.12	-0.45	14.18	250.85
11	TANF	26-39	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.9231	1.007	325.83	-0.62	0.00	325.21
12	TANF	26-39	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	2.0076	1.007	340.15	-0.65	8.48	347.98
13	TANF	40-44	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	1.9231	1.007	325.83	-0.62	0.00	325.21
14	TANF	40-44	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	2.0076	1.007	340.15	-0.65	8.48	347.98
15	TANF	45-64	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.4647	1.007	587.03	-1.12	0.00	585.91
16	TANF	45-64	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.6484	1.007	618.15	-1.17	0.00	616.98
17	TANF	65+	M	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.4647	1.007	587.03	-1.12	0.00	585.91
18	TANF	65+	F	128.14	28.77	3.67	6.87	167.45	1.0048	1.0000	1.000	3.6484	1.007	618.15	-1.17	0.00	616.98
19	ABAD	<1	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
20	ABAD	<1	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
21	ABAD	1-4	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
22	ABAD	1-4	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
23	ABAD	5-14	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
24	ABAD	5-14	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
25	ABAD	15-20	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
26	ABAD	15-20	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
27	ABAD	21-25	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
28	ABAD	21-25	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
29	ABAD	26-39	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
30	ABAD	26-39	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
31	ABAD	40-44	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
32	ABAD	40-44	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
33	ABAD	45-64	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
34	ABAD	45-64	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
35	ABAD	65+	M	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
36	ABAD	65+	F	663.19	166.74	25.03	13.75	868.71	0.9944	1.0000	1.000	1.0000	1.007	869.89	-1.65	1.42	869.66
37	OAA	65+	M	663.19	166.74	25.03	13.75	868.71	0.9960	1.0000	0.821	1.0000	1.007	715.33	-1.36	0.00	713.97
38	OAA	65+	F	663.19	166.74	25.03	13.75	868.71	0.9960	1.0000	0.821	1.0000	1.007	715.33	-1.36	0.00	713.97
59.9	rMCR	All	F	4,057.70	1,795.41	440.36	0.00	6,293.47	0.9938	1.0000	1.000	1.0000	1.007	6,298.23	-11.97	0.00	6,286.26

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

October 8, 2009

NOTICE
TO
CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Cheryl Bupp (517) 241-7933 **Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

The terms and conditions of this Contract are those of RFP #071I9200125, this Contract Agreement and the vendor's quote dated May 21, 2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the vendor, those of the State take precedence.

Current Authorized Spend Limit: $214,285,714.29

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B0200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (313) 465-1519 **Beverly Allen**
OmniCare Health Plan, Inc. **1333 Gratiot, Suite 400** **Detroit, MI 48207** **baallen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**

Contract Compliance Inspector: Cheryl Bupp (517) 241-7933
Comprehensive Health Care Program – Department of Community Health (Oakland, Wayne)

CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of RFP #071I9200125, this Contract Agreement and the vendor's quote dated May 21, 2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the vendor, those of the State take precedence.

Current Authorized Spend Limit: $214,285,714.29

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the RFP #071I9200125. Orders for delivery may be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

FOR THE CONTRACTOR:	**FOR THE STATE:**
OmniCare Health Plan, Inc. Firm Name	Signature
Authorized Agent Signature	**Sergio Paneque, Director** Name/Title
Authorized Agent (Print or Type)	**Business Services Administration** Division
Date	Date

STATE OF MICHIGAN
Department of Management and Budget
Purchasing Operations

Contract No. 071B0200018
Comprehensive Health Care Program for the
Michigan Department of Community Health

Buyer Name: Kevin Dunn
Telephone Number: (517) 241-4225
E-Mail Address: dunnk3@michigan.gov

TABLE OF CONTENTS

Article 1 – Statement of Work (SOW) 15
1.010 Project Identification 15
1.011 Project Request 15
1.012 Background 15
A. Value Purchasing 15
B. Managed Care Direction 15
1.020 Scope of Work and Deliverables 15
1.021 In Scope 15
A. General Objectives 15
B. Specific Objectives 16
C. Service Area 16
(1) Regions 16
(2) Multiple Region Service Areas 16
(3) Contiguous County Service Areas 17
(4) Contiguous County Exception – Wayne and Oakland Counties 17
1.022 Work and Deliverables 17
A. Medicaid Eligibility and CHCP Enrollment 17
(1) Enrollment Services 18
(2) Initial Enrollment 18
(3) Enrollment Lock-In and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions 18
(4) Rural Area Exception 19
(5) Preferred Option Program 19
(6) Enrollment Date 19
(7) Newborn Enrollment 20
(8) Automatic Re-Enrollment 20
(9) Enrollment Errors by DCH 20
(10) Enrollees Who Move Out of the Contractor's Service Area 20
B. Disenrollment Requests Initiated by the Contractor 21
(1) Special Disenrollments 21
(2) CSHCS Eligibility and Enrollment 21
(3) Long-Term Care 21
(4) Administrative Disenrollments 22
C. Disenrollment Requests Initiated by the Enrollee 22
(1) Medical Exception 22
(2) Disenrollment for Cause 22
D. Objectives for Contractor Accountability 22
E. Services 22
(1) Covered Services 22
(2) Enhanced Services 23
(3) Services Covered Outside of the Contract 24
(4) Services Prohibited or Excluded under Medicaid 24
F. Special Coverage Provisions 24
(1) Emergency Services 24
(2) Out-of-Network Services 25
(3) Family Planning Services 25
(4) Federally Qualified Health Centers (FQHCs) 26
(5) Co-Payments 26
(6) Abortions 26
(7) Pharmacy 26
(8) Well Child Care/Early and Periodic Screening, Diagnosis and Treatment Program 27
(9) Immunizations 28
(10) Transportation 28
(11) Transplant Services 29
(12) Communicable Disease Services 29
(13) Restorative Health Services 29
(14) Child and Adolescent Health Centers and Programs 29

(15)Hospice Services 30
(16)Twenty Visit Mental Health Outpatient Benefit 30
(17)Persons with Special Health Care Needs 30
(18)Case Management/Disease Management 30
(19)Pregnant Women 30
(20)Tobacco Cessation Treatment 30
G. Inclusion 30
H. Enrollee Services 31
(1) General 31
(2) Enrollee Education 31
(3) Member Materials 31
I. Grievance and Appeal Policies and Procedures 33
(1) Contractor Grievance/Appeal Policy and Procedures Requirements 33
(2) Notice to Enrollees of Grievance Procedure 34
(3) Notice to Enrollees of Appeal Procedure 34
(4) Adverse Action Notice 34
(5) State Medicaid Appeal Process 34
(6) Expedited Appeal Process 34
J. Confidentiality 35
K. Accreditation/Certification Requirements 35
L. Observance of Federal, State and Local Laws 35
(1) Special Waiver Provisions for CHCP 35
(2) Fiscal Soundness of the Risk-Based Contractor 35
(3) Prohibited Affiliations with Individuals Debarred by Federal Agencies 36
(4) Public Health Reporting 36
(5) Compliance with CMS Regulation 36
(6) Compliance with Health Insurance Portability and Accountability Act Regulation 36
(7) Advanced Directives Compliance 36
(8) Medicaid Policy 37
(9) Compliance with False Claims Acts 37
(10)Protection of Enrollees against Liability for Payment and Balanced Billing 37
M. Disclosure of Physician Incentive Plan 37
N. Policies, Procedures and Operational Plans 37
(1) General 37
(2) Availability upon Request 37
O. Program Integrity 37
(1) General 37
(2) Reporting 38
P. Management Information Systems 38
(1) MIS Capability 38
(2) Enrollment Files 39
(3) Data Accuracy 39
(4) Automated Contract Tracking System 39
Q. Provider Services (In-Network and Out-of-Network) 39
R. Provider Network and Health Service Delivery Criteria 40
(1) General 40
(2) Network Requirements 40
(3) Provider Network File and PCP Submission File 41
S. Primary Care Provider (PCP) Standards 41
(1) PCP Choice 41
(2) Access to Care 24 Hours per Day and 7 Days per Week 41
(3) PCP Availability 42
(4) Maternity Care 42
T. Network Changes 42
U. Provider Contracts 42
(1) Required Provisions 42
(2) Provider Participation 43
V. Provider Credentialing 43
(1) Credentialing 43

(2) Recredentialing ... 43
W. Coordination of Care with Public and Community Providers and Organizations ... 43
(1) Local Organizations and Providers ... 43
(2) Maternal Infant Health Program Providers ... 44
X. Coordination of Care with Local Behavioral Health and Developmental Disability Providers ... 44
Y. Payment to Providers ... 44
(1) Electronic Billing Capacity ... 45
(2) Payment Resolution Process ... 45
(3) Arbitration/Rapid Dispute Resolution ... 45
(4) Post-Payment Review ... 45
(5) Total Payment ... 45
(6) Enrollee Liability for Payment ... 45
(7) Hospital Payments ... 46
Z. Quality Assessment and Performance Improvement Program ... 46
(1) Quality Assessment and Performance Improvement Program (QAPI) ... 46
(2) Annual Effectiveness Review ... 47
(3) Annual Performance Improvement Projects ... 47
(4) Performance Monitoring ... 47
(5) External Quality Review ... 47
(6) Consumer Survey ... 47
AA. Utilization Management ... 48
(1) The major components of the Contractor's utilization management (UM) program ... 48
(2) Prior Approval Policy and Procedure ... 48
BB. Third Party Resource Requirements ... 48
CC. Marketing ... 49
(1) General Information ... 49
(2) Examples of Allowed and Prohibited Marketing Locations and Practices ... 49
(3) Health Fairs ... 50
(4) Marketing Materials ... 50
DD. Contractor On-Site Reviews ... 50
EE. Contract Remedies and Sanctions ... 51
FF. Medical Records ... 51
(1) Medical Record Maintenance ... 52
(2) Medical Record Confidentiality/Access ... 52
1.030 Roles and Responsibilities ... 52
1.031 Contractor Staff, Roles, and Responsibilities ... 52
A. Organizational Structure ... 52
B. Governing Body ... 53
C. Administrative Personnel ... 53
(1) Executive Management ... 53
(2) Medical Director ... 53
(3) Quality Improvement and Utilization Director ... 54
(4) Chief Financial Officer ... 54
(5) Member Services Director ... 54
(6) Provider Services Director ... 54
(7) Grievance/Appeal Coordinator ... 54
(8) Management Information System Director ... 54
(9) Compliance Officer ... 54
(10) Designated Liaisons ... 54
(11) Support/Administrative Staff ... 54
1.032 Responsibilities of the Michigan Department of Community Health ... 54
1.040 Project Plan ... 55
1.041 Project Plan Management – Deleted/Not Applicable ... 55
1.042 Reports ... 55
A. Data Reporting ... 55
(1) General ... 55
(2) Annual Report ... 55
(3) Additional Financial Reports ... 56
(4) HEDIS Submission ... 56

(5) Encounter Data Submission 56
(6) Claims Reporting 57
(7) Semi-Annual Grievance and Appeal Report 57
B. Release of Report Data 57
1.050 Acceptance – Deleted/Not Applicable 57
1.051 Criteria – Deleted/Not Applicable 57
1.052 Final Acceptance – Deleted/Not Applicable 57
1.060 Proposal Pricing 57
1.061 Proposal Pricing – Deleted/Not Applicable 57
A. Payment Provisions 57
B. Contractor Performance Bonus 58
C. Payment Option 58
1.063 Tax Excluded from Price 58
1.070 Additional Requirements – Deleted/Not Applicable 59
1.071 Additional Terms and Conditions specific to this Contract – Deleted/Not Applicable 59
Article 2 - Terms and Conditions 60
2.000 Contract Structure and Term 60
2.001 Contract Term 60
2.002 Options to Renew 60
2.003 Legal Effect 60
2.004 Attachments & Exhibits 60
2.005 Ordering – Deleted/Not Applicable 60
2.006 Order of Precedence 60
2.007 Headings 60
2.008 Form, Function & Utility – Deleted/Not Applicable 60
2.009 Reformation and Severability 60
2.010 Consents and Approvals 60
2.011 No Waiver of Default 60
2.012 Survival 61
2.020 Contract Administration 61
2.021 Issuing Office 61
2.022 Contract Compliance Inspector (CCI) 61
2.023 Project Manager 61
2.024 Change Requests 62
2.025 Notices 62
2.026 Binding Commitments 62
2.027 Relationship of the Parties 62
2.028 Covenant of Good Faith 63
2.029 Assignments 63
2.030 General Provisions 63
2.031 Media Releases 63
2.032 Contract Distribution 63
2.033 Permits 63
2.034 Website Incorporation 63
2.035 Future Bidding Preclusion – Delete/Not Applicable 63
2.036 Freedom of Information 63
2.037 Disaster Recovery 63
2.040 Financial Provisions 63
2.041 Fixed Prices for Services/Deliverables – Deleted/Not Applicable 63
2.042 Adjustments for Reductions in Scope of Services/Deliverables – Deleted/Not Applicable 64
2.043 Services/Deliverables Covered 64
2.045 Pro-ration – Deleted/Not Applicable 64
2.046 Antitrust Assignment 64
2.047 Final Payment 64
2.048 Electronic Payment Requirement 64
2.050 Taxes 64
2.051 Employment Taxes 64
2.052 Sales and Use Taxes 64

2.060 Contract Management ... 64
2.061 Contractor Personnel Qualifications ... 64
2.062 Contractor Key Personnel – Deleted/Not Applicable ... 64
2.063 Re-assignment of Personnel at the State's Request – Deleted/Not Applicable ... 64
2.064 Contractor Personnel Location – Deleted/Not Applicable ... 64
2.065 Contractor Identification – Deleted/Not Applicable ... 65
2.066 Cooperation with Third Parties ... 65
2.067 Contractor Return of State Equipment/Resources – Deleted/Not Applicable ... 65
2.068 Contract Management Responsibilities – Deleted/Not Applicable ... 65
2.070 Subcontracting by Contractor ... 65
2.071 Contractor Full Responsibility ... 65
2.072 State Consent to Delegation ... 66
2.073 Subcontractor Bound to Contract ... 66
2.074 Flow Down ... 66
2.075 Competitive Selection ... 66
2.080 State Responsibilities ... 66
2.081 Equipment – Deleted/Not Applicable ... 66
2.082 Facilities – Deleted/Not Applicable ... 66
2.090 Security ... 66
2.091 Background Checks ... 66
2.092 Security Breach Notification ... 67
2.100 Confidentiality ... 67
2.101 Confidentiality ... 67
2.102 Protection and Destruction of Confidential Information ... 67
2.103 Exclusions ... 67
2.104 No Implied Rights ... 67
2.105 Respective Obligations ... 68
2.110 Records and Inspections ... 68
2.111 Inspection of Work Performed ... 68
2.112 Examination of Records ... 68
2.113 Retention of Records ... 68
2.114 Audit Resolution ... 68
2.115 Errors ... 68
2.120 Warranties ... 68
2.121 Warranties and Representations ... 68
2.122 Warranty of Merchantability – Deleted/Not Applicable ... 69
2.123 Warranty of Fitness for a Particular Purpose – Deleted/Not Applicable ... 70
2.124 Warranty of Title – Deleted/Not Applicable ... 70
2.125 Equipment Warranty – Deleted/Not Applicable ... 70
2.126 Equipment to be New – Deleted/Not Applicable ... 70
2.127 Prohibited Products – Deleted/Not Applicable ... 70
2.128 Consequences For Breach ... 70
2.130 Insurance ... 70
2.131 Liability Insurance ... 70
2.132 Subcontractor Insurance Coverage ... 71
2.133 Certificates of Insurance and Other Requirements ... 74
2.140 Indemnification ... 75
2.141 General Indemnification ... 75
2.142 Code Indemnification ... 75
2.143 Employee Indemnification ... 75
2.144 Patent/Copyright Infringement Indemnification ... 75
2.145 Continuation of Indemnification Obligations ... 75
2.146 Indemnification Procedures ... 75
2.150 Termination/Cancellation ... 76
2.151 Notice and Right to Cure ... 76
2.152 Termination for Cause ... 76
2.153 Termination for Convenience ... 77
2.154 Termination for Non-Appropriation ... 77
2.155 Termination for Criminal Conviction ... 77

2.156 Termination for Approvals Rescinded ... 77
2.157 Rights and Obligations upon Termination ... 77
2.158 Reservation of Rights ... 78
2.160 Termination by Contractor ... 78
2.161 Termination by Contractor ... 78
2.170 Transition Responsibilities ... 78
2.171 Contractor Transition Responsibilities ... 78
2.172 Contractor Personnel Transition ... 78
2.173 Contractor Information Transition ... 79
2.174 Contractor Software Transition ... 79
2.175 Transition Payments ... 79
2.176 State Transition Responsibilities ... 79
2.180 Stop Work ... 79
2.181 Stop Work Orders ... 79
2.182 Cancellation or Expiration of Stop Work Order ... 79
2.183 Allowance of Contractor Costs ... 79
2.190 Dispute Resolution ... 79
2.191 In General ... 79
2.192 Informal Dispute Resolution ... 80
2.193 Injunctive Relief ... 80
2.194 Continued Performance ... 80
2.200 Federal and State Contract Requirements ... 81
2.201 Nondiscrimination ... 81
2.202 Unfair Labor Practices ... 81
2.203 Workplace Safety and Discriminatory Harassment ... 81
2.210 Governing Law ... 81
2.211 Governing Law ... 81
2.212 Compliance with Laws ... 81
2.213 Jurisdiction ... 81
2.220 Limitation of Liability ... 81
2.221 Limitation of Liability ... 81
2.230 Disclosure Responsibilities ... 82
2.231 Disclosure of Litigation ... 82
2.233 Bankruptcy ... 82
2.240 Performance – Deleted/Not Applicable ... 82
2.241 Time of Performance – Deleted/Not Applicable ... 82
2.242 Service Level Agreements (SLAs) – Deleted/Not Applicable ... 83
2.243 Liquidated Damages – Deleted/Not Applicable ... 83
2.244 Excusable Failure – Deleted/Not Applicable ... 83
2.250 Approval of Deliverables – Deleted/Not Applicable ... 83
2.251 Delivery Responsibilities – Deleted/Not Applicable ... 83
2.252 Delivery of Deliverables – Deleted/Not Applicable ... 83
2.253 Testing – Deleted/Not Applicable ... 83
2.254 Approval of Deliverables, In General – Deleted/Not Applicable ... 83
2.255 Process For Approval of Written Deliverables – Deleted/Not Applicable ... 83
2.256 Process for Approval of Services – Deleted/Not Applicable ... 83
2.257 Process for Approval of Physical Deliverables – Deleted/Not Applicable ... 83
2.258 Final Acceptance – Deleted/Not Applicable ... 83
2.260 Ownership – Deleted/Not Applicable ... 83
2.270 State Standards ... 83
2.271 Existing Technology Standards ... 83
2.272 Acceptable Use Policy ... 83
2.280 Extended Purchasing – Deleted/Not Applicable ... 83
2.290 Environmental Provision ... 83
2.291 Environmental Provision ... 83

List of Appendices

Appendix 1: Rural Area Exception Counties 111
Appendix 2: DCH Financial Monitoring Standards 112
Appendix 3: Reporting Requirements for Medicaid Health Plans 113
Appendix 4: Medicaid Managed Care Performance 115
Appendix 5: Performance Bonus Template 115

List of Attachments

Attachment A: Contractor's Approved Service Areas 131
Attachment B: Contractor's Awarded Rates 132

DEFINITION OF TERMS

Term	Definition
24x7x365	24 hours a day, seven days a week, and 365 days a year (including the 366th day in a leap year).
AAP	American Academy of Pediatrics.
AAFP	American Academy of Family Physicians
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
ACIP	Advisory Committee on Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
ACP	American College of Physicians
Additional Service	Any Services/Deliverables within the scope of the Contract, but not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.
Administrative Law Judge	A person designated by DCH to conduct the Administrative Hearing in an impartial or unbiased manner.
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated.
AOA	American Osteopathic Association
Appeal	As defined in 42 CFR 438.400(3)(b). A request for review of a Contractor's decision that results in any of the following actions: • The denial or limited authorization of a requested service, including the type or level of service; • The reduction, suspension, or termination of a previously authorized service; • The denial, in whole or in part, of payment for a properly authorized and covered service; • The failure to provide services in a timely manner, as defined by the State; • The failure of a Contractor to act within the established timeframes for grievance and appeal disposition; • For a resident of a rural area with only one Medicaid health plan, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
Audit Period	Meaning given in **Section 2.112.**
Balanced Budget Act (BBA)	The Balanced Budget Act (BBA) of 1997 (Public law 105-33). The BBA establishes the rules and regulations for the 1915 (b) waiver under which the CHCP is administered.
Beneficiary	Any person determined eligible for the Medical Assistance Program as defined below.
Blanket Purchase Order	Alternative term for "Contract" used in the State's computer system (Michigan Automated Information Network) MAIN.
Business Day	Any day other than a Saturday, Sunday or State-recognized legal holiday (as identified in the Collective Bargaining Agreement for State employees) from 8:00am EST through 5:00pm EST unless otherwise stated (whether capitalized or not).
CAHPS®	Consumer Assessment of Healthcare Providers and Systems.
CAC	Clinical Advisory Committee appointed by DCH.

Capitation Rate	A fixed per person monthly rate payable to the Contractor by DCH for provision of all Covered Services defined within this Contract.
CCI	Contract Compliance Inspector.
CDPS	Chronic Illness and Disability Payment System.
CFR	Code of Federal Regulations.
CHCP	Comprehensive Health Care Program. Capitated health care services for Medicaid Beneficiaries in specified counties provided by Medicaid health plans that contract with the State.
Clean Claim	Clean Claim means that as defined in MCL 400.111i.
CMHSP	Community Mental Health Services Program.
CMS	Centers for Medicare and Medicaid Services.
Contract	A binding agreement entered into by the State of Michigan and the Contractor; see also "Blanket Purchase Order."
Contractor	The successful Bidder who was awarded a Contract. In this Contract, the terms Contractor, HMO, Contractor's plan, Medicaid health plan, MHP and health plan are used interchangeably.
Covered Services	All services provided under Medicaid, as defined in Section 1.022(E)(1), 1.022(E)(2), and 1.022(F) that the Contractor has agreed to provide or arrange to be provided.
CSHCS	Children's Special Health Care Services.
Days	Calendar days unless otherwise specified.
DCH	The Michigan Department of Community Health and its designated agents.
DCH Administrative Hearing (Fair Hearing)	An impartial review by DCH of a decision made by the Contractor that the enrollee believes is inappropriate. An Administrative Law Judge conducts the Administrative Hearing.
DEG	Data Exchange Gateway.
Deleted/Not Applicable	The Section is not applicable or included in this Contract. This is used as a placeholder to maintain consistent numbering.
Deliverable	Physical goods and/or commodities as required or identified by a Statement of Work.
Department	The Michigan Department of Community Health and its designated agents.
DHS	The Michigan Department of Human Services.
DMB	The Michigan Department of Management and Budget.
DME	Durable medical equipment.
DRG	Diagnosis related group.
EFT	Electronic funds transfer.
Emergency Medical Care/Services (EMC)	Those services necessary to treat an emergency medical condition. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
EMTALA	Emergency Treatment and Active Labor Act.
Enrollee	Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in a given Medicaid health plan.
Enrollment Capacity	The number of persons that the Contractor can serve through its provider network under a Contract with the State. Enrollment Capacity is determined by a Contractor based upon its provider network organizational capacity and available risk-based capital.
Enrollment Services Contractor	An entity contracted by the DMB to contact and educate general Medicaid and Children's Special Health Care Services Beneficiaries about managed care and to enroll, disenroll, and change enrollments for these Beneficiaries.

Environmentally Preferable Product	Product or service that has a lesser or reduced effect on human health and the environment when compared with competing products or services that serve the same purpose. Such products or services may include, but are not limited to, those which contain recycled content, minimize waste, conserve energy or water, and reduce the amount of toxics either disposed of or consumed.
EOB	Explanation of Benefits.
EPLS	Excluded Parties Listing System.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment.
EQR	External Quality Review.
Expedited Appeal	An appeal conducted when the Contractor determines (based on the enrollee request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.
Expedited Authorization Decision	An authorization decision required to be expedited due to a request by the provider or determination by the Contractor that following the standard timeframe could seriously jeopardize the enrollee's life or health.
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
FIP	Financial Independence Program.
FFS	Fee-for-service. A reimbursement methodology that provides a payment amount for each individual service delivered.
FOIA	Freedom of Information Act.
FQHC	Federally Qualified Health Center.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).
Grievance	Grievance means an expression of dissatisfaction about any matter other than an action subject to appeal. (42 CFR 438.400)
GME	Graduate Medical Education.
GSA	The United States General Services Administration.
Hazardous Material	Any material defined as hazardous under the latest version of federal Emergency Planning and Community Right-to-Know Act of 1986 (including revisions adopted during the term of the Contract).
Health Benefit Manager	Any entity that performs the administration and management of one or more of the required health care benefits listed in Section 1.022(E) of the Contract under a written contract or agreement with the Contractor.
Healthcare Effectiveness Data and Information Set (HEDIS®)	The result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a group of 60 performance measures that gives employers some objective information with which to evaluate health plans and hold them accountable.
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMO	An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 500.3501.
ICD-9-CM	International Statistical Classification of Diseases.
ICF/MR	Intermediate Care Facilities for the Mentally Retarded
Incident	Any interruption in Services.
Key Personnel	Any personnel designated in **Section 1.031** as Key Personnel.
Long Term Care Facility	Any facility licensed and certified by the Michigan Department of Community Health, in accordance with the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, to provide inpatient nursing care services.

Managing Employee	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.
Marketing	Marketing means any communication, from a Contractor directed to a Medicaid Beneficiary who is not enrolled in the Contractor's plan, that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another health plan's Medicaid product.
MCIR	Michigan Care Improvement Registry.
MCL	Michigan Compiled Laws.
Medicaid/Medical Assistance Program	A federal/state program authorized by the Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of 1939 PA 280, as amended, MCL 400.1 – 400.122; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.
Medicaid Health Plan	Managed care organizations that provide or arrange for the delivery of comprehensive health care services to Medicaid enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as a Health Maintenance Organization (HMO). See also Contractor.
MERF	Medical Eligibility Referral Form.
MSA	Medical Services Administration, the agency within the Department of Community Health responsible for the administration of the Medicaid Program.
NAIC	National Association of Insurance Commissioners.
NCQA	National Committee for Quality Assurance
New Work	Any Services/Deliverables outside the scope of the Contract and not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.
OFIR	Office of Financial and Insurance Regulation.
PA	Public Act.
PACE	Program for All-Inclusive Care for the Elderly.
PCP	Primary Care Provider. Those providers within the MHPs who are designated as responsible for providing or arranging health care for specified enrollees of the Contractor.
Persons with Special Health Care Needs	Enrollees who have lost eligibility for the Children's Special Health Care Services (CSHCS) program due to the program's age requirements.
PIHP	Prepaid Inpatient Health Plan.
PIP	Physician Incentive Plan
PMPM	Per Member Per Month.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's enrollees.
Provider	Provider means a health facility or a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211.
QAPI	Quality Assessment and Performance Improvement.
QIC	Quality Improvement Committee.
RFP	Request for Proposal designed to solicit proposals for services.
Rural	Rural is defined as any county not designated as metropolitan or outlying metropolitan by the 2000 U. S. Census.
Services	Any function performed for the benefit of the State.
Source Reduction	Any practice that reduces the amount of any hazardous substance, pollutant, or contaminant entering any waste stream or otherwise released into the environment prior to recycling, energy recovery, treatment, or disposal.
SOW	Statement of Work.
SSI	Social Security Income.

State	The State of Michigan.
State Location	Any physical location where the State performs work. State Location may include state-owned, leased, or rented space.
STD	Sexually-Transmitted Disease.
Subcontractor	A Subcontractor is any person or entity that performs a required, ongoing administrative or Health Benefit management function of the Contractor under this Contract as defined in Section 2.070 of this Contract.
TANF	Temporary Assistance to Needy Families.
TPA	Third Party Administrator.
TPL	Third Party Liability.
UM	Utilization Management.
USC	United States Code.
VFC	Vaccines for Children program. A federal program which makes vaccine available free to immunize children age 18 and under who are Medicaid eligible.
Well Child Visits/EPSDT	Early and periodic screening, diagnosis, and treatment program. A child health program of prevention and treatment intended to ensure availability and accessibility of primary, preventive, and other necessary health care resources and to help Medicaid children and their families to effectively use these resources.
WIC	Women Infant and Children Program.
Work in Progress	A Deliverable that has been partially prepared, but has not been presented to the State for Approval.
Work Product	Any data compilations, reports, and other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of and in furtherance of performing the services required by this Contract.

Article 1 – Statement of Work (SOW)

1.010 Project Identification

1.011 Project Request

This Contract is held between the State and the Contractor to provide Comprehensive Health Care Program (CHCP) Services for Medicaid beneficiaries in the service areas within the State of Michigan, as described in Attachment A. The Contract between the State and the Contractor (hereafter referred to as "this Contract") is a unit price-Per Member Per Month Capitated Rate (PMPM) Contract (see Attachment B) and is subject to the terms included in Article 2. Since beneficiaries must have a choice among Contractors, the State cannot guarantee an exact number of enrollees to any Contractor.

1.012 Background

A. Value Purchasing

The Michigan Department of Community Health (DCH) merges policy, programs, and resources to enable the State to continue to be an effective purchaser of health care services for the Medicaid population. As the single State agency responsible for health policy and purchasing of health care services using State appropriated and federal matching funds, DCH employs fiscally prudent purchasing while ensuring quality and access. DCH continues to focus on "value purchasing." Value purchasing involves aligning financing incentives to stimulate appropriate changes in the health delivery system that will:

- Require organization and accountability for the full range of benefits
- Encourage creativity to provide the widest range of services with limited resources
- Maintain and improve access to and quality of care
- Continue to make advancements in cost efficiency
- Monitor improvements in the health status of the community to ensure that Contractor's performance supports continued improvements

B. Managed Care Direction

Under the CHCP, the State selectively awards risk-based contracts to Contractors with demonstrated capability and capacity for managing comprehensive care through a performance contract. The Contractors are partners with the State in providing fiscally prudent services to improve and maintain the health status of Medicaid beneficiaries. Michigan's CHCP continues to focus on quality of care, accessibility, and cost-effectiveness.

Michigan's financial status dictates that Michigan must control the Medicaid budget. The recent economic downturn in Michigan has led to a decline in available State revenues. At the same time, Medicaid expenditures have grown rapidly due to several factors such as increases in the number of persons eligible for assistance; increases in the utilization of services; and inflation in service costs. The Medicaid budget must be controlled but, at the same time, access to quality health care for the Medicaid population must be preserved.

Two categories of specialized services are available outside of the CHCP: (1) specialty behavioral health services and (2) services for persons with developmental disabilities. These services are clearly defined as beyond the scope of benefits that are included in the CHCP. Any Contractor contracting with the State as a capitated managed care provider will be responsible for coordinating access to these specialized services with those providers designated by the State to provide them. The criteria for contracted Medicaid health plans (MHPs) include the implementation of agreements with the behavioral health and developmental disability providers who are under contract with DCH.

1.020 Scope of Work and Deliverables

1.021 In Scope

A. General Objectives

The general Contract objectives of the State are:

- Access to primary and preventive care
- Establishment of a "medical home" and the coordination of all necessary health care services
- Provision of high quality medical care that provides continuity of care and is appropriate for the individual
- Operation of a health care delivery system that enables Michigan to control and predict the cost of medical care for the Medicaid population

B. Specific Objectives

When providing services under the CHCP, the Contractor must take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population in the CHCP. The Contractor must recognize that special needs will vary by individual and by county or region. The Contractor must have an underlying organizational capacity to address the special needs of their enrollees, such as: responding to requests for assignment of specialists as Primary Care Providers (PCP), assisting in coordinating with other support services, and generally responding and anticipating needs of enrollees with special or culturally diverse needs. Under their covered service responsibilities, the Contractor is expected to provide early prevention and intervention services for enrollees with specific needs, as well as all other enrollees.

As an example, while support services for persons with developmental disabilities may be outside of the direct service responsibility of the Contractor, the Contractor does have the responsibility to assist in coordinating arrangements to ensure these persons receive necessary support services. This coordination must be consistent with the person-centered planning principles established within the Michigan's Mental Health Code.

Another example is enrollees who have chronic illnesses such as diabetes or end-stage renal disease. In these instances, it may be more appropriate to assign a specialist within the Contractor's network as the PCP. When a Contractor designates a physician specialist as the PCP, that PCP-specialist will be responsible for coordinating all continuing medical care for the assigned Enrollee.

C. Service Area

(1) Regions

DCH will divide the delivery of covered services into 10 regions.

Contractors must establish a network of providers that guarantees access to required services for the entire region or the applicable counties in the region the Contractor proposes to service. The Contractor must provide a complete description of the provider network to DCH upon request.

The counties included in the specific regions are as follows:

Region 1: Wayne

Region 2: Hillsdale, Jackson, Lenawee, Livingston, Monroe, and Washtenaw

Region 3: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren

Region 4: Allegan, Antrim, Benzie, Charlevoix, Cheboygan, Emmet, Grand Traverse, Ionia, Kalkaska, Kent, Lake, Leelanau, Manistee, Mason, Mecosta, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa, and Wexford

Region 5: Clinton, Eaton, and Ingham

Region 6: Genesee, Lapeer, and Shiawassee

Region 7: Alcona, Alpena, Arenac, Bay, Clare, Crawford, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, and Tuscola

Region 8: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft

Region 9: Macomb and St. Clair
Region 10: Oakland

(2) Multiple Region Service Areas

The Contractor agrees to tailor the services to each individual region in terms of the provider network, enrollment capacity, and any special health issues applicable to the region.

DCH may consider Contractors' requests for service area expansion during the term of the Contract. Approval of service area expansion requests will be at the sole discretion of DCH and will be contingent upon the need for additional capacity in the counties proposed under the expansion request.

(3) Contiguous County Service Areas
The Contractor may propose to provide service to counties through the use of provider networks in contiguous counties. The Contractor must identify the contiguous counties with an available provider network and the counties in the region that will be served through this provider network. A complete description of the provider network must be provided.

(4) Contiguous County Exception – Wayne and Oakland Counties
The Contractor may request approval to serve beneficiaries residing in a specific zip code area in a county directly contiguous to the Contractor's approved service area. The Contractor must meet all specifications outlined by DCH and receive DCH approval for the contiguous county exception. The contiguous county will be eligible for voluntary enrollments only; DCH will not auto-assign beneficiaries into the Contractor's plan in the contiguous county. This exception applies solely to Wayne and Oakland Counties.

1.022 Work and Deliverables
The Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below.

A. Medicaid Eligibility and CHCP Enrollment
The Michigan Medicaid program arranges for and administers medical assistance to approximately 1.4 million beneficiaries. This includes those individuals eligible for, or receiving, federally aided financial assistance, those deemed categorically needy by the Department of Human Services (DHS) and the medically needy populations. Eligibility for Michigan's Medicaid program is based on a combination of financial and non-financial factors. The State has the sole authority for determining whether individuals or families meet any of the eligibility requirements as specified for enrollment in the CHCP.

Individuals who attain eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through two months post-partum or post-loss of pregnancy. Their newborns are usually guaranteed coverage for two months and may be covered for one full year.

Within the Medicaid eligible population, there are groups that must enroll in the CHCP, groups that may voluntarily enroll, and groups that are excluded from participation in the CHCP as follows:

Medicaid Eligible Groups Who Must Enroll in the CHCP:
- Families with children receiving assistance under the Financial Independence Program (FIP)
- Persons under age 21 who are receiving Medicaid
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged
- Pregnant women

Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
- Migrants
- Native Americans

Medicaid Eligible Groups Excluded From Enrollment in the CHCP:
- Persons without full Medicaid coverage
- Persons with Medicaid who reside in an Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or a State psychiatric hospital
- Persons receiving long term care (custodial care) in a licensed nursing facility
- Persons being served under the Home & Community Based Elderly Waiver
- Persons enrolled in Children's Special Health Care Services (CSHCS)
- Persons with commercial HMO coverage, including Medicare HMO coverage

- Persons in PACE (Program for All-inclusive Care for the Elderly)
- Deductible clients (also known as Spenddown)
- Children in foster care or in Child Care Institutions
- Persons in the Refugee Assistance Program
- Persons in the Repatriate Assistance Program
- Persons in the Traumatic Brain Injury program
- Persons with both Medicare and Medicaid eligibility
- Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
- Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan
- Persons incarcerated in a city, county, State, or federal correctional facility

(1) Enrollment Services

The State is required to contract for services to help beneficiaries make informed choices regarding their health care, assist with client satisfaction and access surveys, and assist beneficiaries in the appropriate use of the Contractor's complaint and grievance systems. DCH contracts with an Enrollment Services Contractor to contact and educate general Medicaid beneficiaries about managed care and to enroll, disenroll, and change enrollment for these beneficiaries. Although this Contract indicates that the enrollment and disenrollment process and related functions will be performed by DCH, generally, these activities are part of the Enrollment Services Contract. Enrollment Services references to DCH are intended to indicate functions that will be performed by either DCH or the Enrollment Services Contractor. All Contractors agree to work closely with DCH and provide necessary information, including provider files.

(2) Initial Enrollment

After a person applies to DHS for Medicaid, she or he will be assessed for eligibility in a Medicaid managed care program. If they are determined eligible for the CHCP, they are given information regarding the Contractors available to them, and the opportunity to speak with an enrollment counselor to obtain more in-depth information and to get answers to any questions or concerns they may have. DCH provides access to a toll-free number to call for information or to designate their preferred Contractor. If beneficiaries do not reside in a county covered by the rural county exception or the preferred option exception, beneficiaries eligible for the CHCP will have full choice of Contractors within their county of residence. Beneficiaries must decide on the Contractor with which they wish to enroll within 30 days from the date of approval of Medicaid eligibility. If they do not voluntarily choose a Contractor within 30 days of approval, DCH will automatically assign the beneficiaries to a Contractor within their county of residence.

Under the automatic enrollment process, beneficiaries will be automatically assigned based on the Contractor's performance in areas specified by DCH. Individuals in a family unit will be assigned together whenever possible. DCH will automatically assign a larger proportion of beneficiaries to Contractors with a higher performance ranking. The performance ranking will be based on such factors as Healthcare Effectiveness Data and Information Set (HEDIS®) scores, blood lead scores, and the ability of the Contractor to consistently meet the quality and administrative performance monitoring standards. The capacity of the Contractor to accept new enrollees and to provide accessibility for the enrollees also will be taken into consideration in automatic beneficiary enrollment. DCH has the sole authority for determining the methodology and criteria to be used for automatic enrollment.

The Contractor will accept as enrolled all enrollees appearing on monthly enrollment reports and infants enrolled by virtue of the mother's enrollment status. The Contractor may not discriminate against beneficiaries on the basis of health needs or health status. The Contractor may not encourage an enrollee to disenroll because of health care needs or a change in health care status. Further, an enrollee's health care utilization patterns may not serve as the basis for disenrollment from the Contractor. This provision does not prohibit the Contractor from conducting DCH-approved outreach activities for CSHCS or other State and federal health care programs.

(3) Enrollment Lock-In and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions

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

(a) During the annual open enrollment period, DCH, or the Enrollment Services Contractor, will notify enrollees of their right to disenroll

(b) Enrollees will be provided with an opportunity to select any Contractor approved for their area during this open enrollment period

(c) Enrollees will be notified that if they do nothing, their current enrollment will continue
(d) Enrollees who choose to remain with the same Contractor will be deemed to have had their opportunity for disenrollment without cause and declined that opportunity until the next open enrollment period
(e) New enrollees or enrollees who change from one Contractor to another will have 90 days from the enrollment begin date with the Contractor to change Contractors without cause
(f) Enrollees who disenroll from a Contractor will be required to change enrollment to another Contractor
(g) All such changes will be approved and implemented by DCH on a calendar month basis

(4) Rural Area Exception

In counties that are designated as rural counties, DCH may implement a Rural Area Exception policy. The policy allows DCH to require mandatory enrollment of Medicaid beneficiaries into a single health plan that is the only health plan with service area approval in the respective rural county. This policy will only be implemented in counties that are designated as "rural" as defined by this Contract. Appendix 1 lists the counties in which DCH has currently, or may in the future, implement the rural area exception.

Enrollees must be permitted to choose from at least two primary care providers (PCPs). Enrollees must have the option of obtaining services from any other network or non-network provider if the following conditions exist:

(a) The type of service or specialist is not available within the HMO
(b) The provider is not part of the network, but is the main source of a service to the enrollee
(c) The only provider available to the enrollee does not, because of moral or religious objections, provide the service the enrollee seeks
(d) Related services must be performed by the same provider and all of the services are not available within the network
(e) DCH determines other circumstances that warrant out-of-network treatment

DCH will determine the rural counties covered by the Rural Area Exception. DCH will determine the method of Contractor selection and payment based on performance measures, provider network, current enrollment, and/or other factors relevant to the area.

(5) Preferred Option Program

In counties in which only one health plan is available for enrollment, DCH may implement a Preferred Option program. This allows DCH to use enrollment in the Preferred Option health plan as the default enrollment option. Beneficiaries in mandatory enrollment categories are notified that they must choose between enrollment in the Contractor's health plan or fee-for-service (FFS) Medicaid. If the beneficiary does not contact the enrollment broker by the specified deadline, the beneficiary is automatically enrolled with the Contractor. Beneficiaries assigned under the Preferred Option program are not locked into the Contractor's health plan and may disenroll at any time without cause.

(6) Enrollment Date

Any changes in enrollment will be approved and implemented by DCH on a calendar month basis. The Contractor is responsible for members until the date of disenrollment.

If a beneficiary is determined eligible during a month, he or she is eligible for the entire month. In some cases, enrollees may be retroactively determined eligible. Once a beneficiary (other than a newborn) is determined to be Medicaid eligible, enrollment with a Contractor will occur on the first day of the next available month following the eligibility determination and enrollment process. The Contractor will not be responsible for paying for health care services during a period of retroactive eligibility and prior to the date of enrollment in their health plan, except for newborns (Refer to Section 1.022(A)(7)). Only full-month capitation payments will be made to the Contractor.

If the beneficiary is in <u>any</u> inpatient hospital setting on the date of enrollment (first day of the month), the Contractor will not be responsible for the inpatient stay or any charges incurred prior to the date of discharge. The Contractor will be responsible for all care from the date of discharge forward. Similarly, if an enrollee is disenrolled from a Contractor and is in <u>any</u> inpatient hospital setting on the date of disenrollment (last day of the month), the Contractor will be responsible for all charges incurred through the date of discharge, subject to the exception for disenrollments based on CSHCS enrollment (Section 1.022(B)(2)).

(7) Newborn Enrollment

At a minimum, newborns are eligible for Medicaid for the month of their birth and may be eligible one year or longer. Newborns of mothers who were eligible and enrolled at the time of the child's birth will be automatically enrolled with the mother's Contractor. The Contractor will be responsible for all covered services for the newborn until notified otherwise by DCH. The Contractor will receive a capitation payment for the month of birth and for all subsequent months of enrollment. Contractors are required to reconcile the plan's birth records with the enrollment information supplied by DCH.

If DCH does not notify the Contractor of the newborn's enrollment within two months of the birth or the child is born outside Michigan, the Contractor is responsible for submitting a newborn notification form to DCH. The Contractor must submit the newborn notification form to DCH within 90 days of the date of birth or 30 days of notification of the birth, whichever is later. If the Contractor submits the newborn notification form after the deadline, the child will be enrolled retroactively for the birth month only. **DCH will not accept requests for newborn enrollment from the Contractor after six months from date of birth.**

(8) Automatic Re-Enrollment

Enrollees who are disenrolled from the Contractor's plan due to loss of Medicaid eligibility or DHS action will be automatically re-enrolled prospectively to the same Contractor provided that they regain eligibility within three months.

(9) Enrollment Errors by DCH

If DCH enrolls a non-eligible person with a Contractor, DCH will retroactively disenroll the person as soon as the error is discovered and will recoup the capitation paid to the Contractor. The Contractor must notify DCH within 15 days of enrollment effective date. If the Contractor does not notify DCH within this time frame, the disenrollment will be prospective. The Contractor may recoup payments from its providers as allowed by Medicaid Policy and as permissible under the Contractor's provider contracts.

(10) Enrollees Who Move Out of the Contractor's Service Area

The Contractor is responsible for services provided to an enrollee who has moved out of the Contractor's service area <u>after</u> the effective date of enrollment until the enrollee is disenrolled from the Contractor. If an enrollee's street address on the enrollment file is outside of the Contractor's service area but the county code does not reflect the new address, the Contractor is responsible for requesting disenrollment within 15 days of the enrollment effective date. When requesting disenrollment, the Contractor must submit verifiable information that an enrollee has moved out of the service area. DCH will expedite prospective disenrollments of enrollees and process all such disenrollments effective the next available month after notification from DHS that the enrollee has left the Contractor's service area. If the county code on the enrollment file is outside of the Contractor's service area, DCH will automatically disenroll the enrollee for the next available month.

Until the enrollee is disenrolled from the Contractor, the Contractor will receive a capitation rate for these enrollees at the approved statewide average rate. The Contractor is responsible for all medically necessary covered and authorized services for these enrollees until they are disenrolled. The Contractor may use its utilization management protocols for hospital admissions and specialty referrals for enrollees in this situation. The Contractor may require enrollees to return to use network providers and provide transportation and/or the Contractor may authorize out-of-network providers to provide medically necessary services.

Enrollment of beneficiaries who reside out of the service area of a Contractor <u>before</u> the effective date of enrollment will be considered an "enrollment error" as described above. The Contractor is responsible for requesting disenrollment within 15 days of the enrollment effective date. DCH will retroactively disenroll these enrollees effective on the date of enrollment.

B. Disenrollment Requests Initiated by the Contractor

(1) Special Disenrollments

The Contractor may initiate special disenrollment requests to DCH based on enrollee actions inconsistent with Contractor membership—for example, if there is fraud, abuse of the Contractor, or other intentional misconduct; or if, the enrollee's abusive or violent behavior poses a threat to the Contractor or provider. The Contractor is responsible for members until the date of disenrollment. Special disenrollment requests are divided into three categories:

(a) Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against Contractor providers, staff, or the public at Contractor locations; or stalking situations

(b) Fraud/misrepresentation involving alteration or theft of prescriptions, misrepresentation of Contractor membership, or unauthorized use of CHCP benefits

(c) Other actions inconsistent with plan membership. Examples include, but are not limited to, the repeated use of non-Contractor providers without referral or when in-network providers are available; discharge from multiple practices of available Contractor's network providers; inappropriate use of prescription medication or drug seeking behaviors including inappropriate use of emergency room facilities for drug-seeking purposes.

A Contractor may not request special disenrollment based on the physical or mental health status of the enrollee. If the enrollee's physical or mental health is a factor in the actions inconsistent with plan membership, the Contractor must document evidence of the Contractor's actions to assist the enrollee in correcting the problem, including appropriate physical and mental health referrals. The Contractor must also document that continued enrollment seriously impairs the Contractor or providers' ability to furnish services to this enrollee or other enrollees. DCH reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment. The effective disenrollment date shall be within 60 days from the date DCH received the complete request from the Contractor that contains all information necessary for DCH to render a decision. If the beneficiary exercises their right of appeal, the effective disenrollment date shall be no later than 30 days following resolution of the appeal.

(2) CSHCS Eligibility and Enrollment

The Contractor may initiate a disenrollment request if the enrollee becomes medically eligible for services under Title V of the Social Security Act (CSHCS) and the family chooses to enroll in the program. Information must be provided in a timely manner using the format specified by DCH. DCH reserves the right to require additional information from the Contractor to assess the need for enrollee disenrollment and to determine the enrollee's eligibility for special services.

If the child is determined medically eligible <u>and</u> if the family decides to enroll in CSHCS, DCH will approve the Contractor's disenrollment request. The effective date of disenrollment is either (1) the first of the month of the child's admission to a facility during which the eligible condition was identified or (2) the first of the month that the Contractor received notification of the child's eligible condition if the child was not admitted to a facility when the eligible condition was identified. The Contractor or hospital must submit a complete Medical Eligibility Referral Form (MERF) containing all necessary signatures and information required by DCH to determine medical eligibility to DCH within 30 calendar days of admission or Contractor's receipt of notification of the eligible condition. If the MERF is not submitted within 30 calendar days of the admission or Contractor's receipt of notification, the effective date of disenrollment will be the first of the month that the Contractor submits the complete MERF. If the family does not choose to enroll in CSHCS, the child will remain in the health plan.

The Contractor is responsible for members until the date of disenrollment. If the enrollee is confined to an inpatient facility at the time of disenrollment, the usual rule regarding payer responsibility does not apply. The Contractor is only responsible for service provided to the enrollee through the date of disenrollment from the health plan.

(3) Long-Term Care

The Contractor may initiate a disenrollment request if the enrollee is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than 45 days. The Contractor must provide DCH with medical documentation to support this type of disenrollment request. Information must be provided in a timely manner using the format specified by DCH. DCH reserves the right to require additional information from the Contractor to assess the need for enrollee disenrollment. The Contractor is responsible for members until the date of disenrollment.

(4) Administrative Disenrollments

The Contractor may initiate disenrollment requests if the enrollee's circumstances change such that the enrollee no longer meets the criteria for enrollment in the Contractor's plan as defined by DCH. The Contractor should request disenrollment within 15 days of identifying the administrative circumstance.

C. Disenrollment Requests Initiated by the Enrollee

(2) Medical Exception

The beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the Contractor at the time of enrollment. The beneficiary must submit a medical exception request to DCH.

(3) Disenrollment for Cause

The enrollee may request that DCH review a request for disenrollment for cause from a Contractor's plan at any time during the enrollment period to allow the beneficiary to enroll in another health plan. Reasons cited in a request for disenrollment for cause may include lack of access to providers or necessary specialty services covered under the Contract or concerns with quality of care. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor.

D. Objectives for Contractor Accountability

Contractor accountability must be established in order to ensure that the State's objectives for managed care are met. Highlights of the State's objectives for Contractor accountability include the following:

(1) Ensuring that all covered services are available and accessible to enrollees promptly and in a manner that ensures continuity
(2) Delivering health care services in a manner that focuses on health promotion and disease prevention and features disease management strategies
(3) Maintaining an administrative and organizational structure that supports a high quality, comprehensive managed care program
(4) Demonstrating the Contractor's provider network and financial capacity to serve the Contractor's expected enrollment of enrollees
(5) Meeting or exceeding the goals set forth for the Contractors in the DCH Quality Strategy
(6) Providing access to appropriate providers, including qualified specialists for all medically necessary services, behavioral health, and developmental disabilities services
(7) Providing assurances that it will not deny enrollment to, expel, or refuse to re-enroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of such assurances at the time of enrollment
(8) Paying providers in a timely manner for all covered services
(9) Providing procedures to ensure program integrity through the detection, prevention, education, and reporting of fraud, waste and abuse and cooperate with DCH and the Department of Attorney General as necessary
(10) Reporting encounter data and aggregate data including inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by DCH
(11) Providing assurances of the Contractor's solvency and guaranteeing that enrollees and the State will not be liable for debts of the Contractor
(12) Meeting all standards and requirements contained in this Contract, and complying with all applicable federal and State laws, administrative rules, and policies promulgated by DCH
(13) Cooperating with the State and/or CMS in all matters related to fulfilling Contract requirements and obligations

E. Services

(2) Covered Services

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified.

The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

(3) Enhanced Services

In conjunction with the provision of covered services, the Contractor must do the following:

- Place strong emphasis on programs to enhance the general health and well-being of enrollees
- Make health promotion programs available to the enrollees
- Promote the availability of health education classes for enrollees
- Provide education for enrollees with, or at risk for, a specific disability or illness
- Provide education to enrollees, enrollees' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities
- Upon request from DCH, collaborate with DCH on projects that focus on improvements and efficiency in the overall delivery of health services

The Contractor agrees that the enhanced services must comply with the marketing, incentive, and other relevant guidelines established by DCH. Marketing and incentive programs related to health promotion programs must be approved by DCH prior to implementation. DCH will be receptive to innovation in the provision of health promotion services and, if appropriate, will seek any federal waivers necessary for the Contractor to implement a desired innovative program.

The Contractor may not charge an enrollee a fee for participating in health education services that fall under the definition of a covered service under this Section of the Contract. A nominal fee may be charged to an enrollee if the enrollee elects to participate in programs beyond the covered services.

(4) Services Covered Outside of the Contract

The following services are not Contractor requirements; however, the Contractor must provide information to the enrollee regarding the availability of these services and coordinate care as required under other terms of this Contract:

- Dental services
- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services (the Contractor is not responsible for the physician cost related to providing psychiatric admission histories and physical. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the Contractor would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), after 45 days
- Outpatient partial hospitalization psychiatric care
- Maternal Infant Health Program (MIHP)
- Mental health services in excess of 20 outpatient visits each calendar year
- Mental health services for enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance.
- Substance abuse services through accredited providers including:
  - Screening and assessment
  - Detoxification
  - Intensive outpatient counseling and other outpatient services
  - Methadone treatment and other substance abuse pharmaceuticals indicated exclusively for substance abuse treatment and specified on DCH's pharmacy vendor's web site under the "Classes for Psychotropic and HIV/AIDS Carve Out" at www.Michigan.fhsc.com
- Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities which are billed through CMHSP providers or Intermediate School Districts.
- Custodial care in a nursing facility
- Home and Community-Based Waiver Program services
- Personal care or home help services
- Traumatic Brain Injury Program Services
- Transportation for services not covered in the CHCP Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities which are billed through Community Mental Health Services Program

(5) Services Prohibited or Excluded under Medicaid; the Contractor is prohibited from using State funds to provide these services

- Elective abortions and related services
- Experimental/investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Services for treatment of infertility

F. Special Coverage Provisions

The Contractor is required to follow specific coverage and payment policies for the services and providers contained in this Section.

(2) Emergency Services

The Contractor must cover emergency services as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USC 1395dd(a)). The enrollee must be screened and stabilized without requiring prior authorization.

The Contractor must ensure that emergency services are available 24 hours per day and 7 days per week. The Contractor is responsible for payment of all out-of-plan or out-of-area emergency services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services. The Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.

(d) Emergency Transportation
The Contractor must provide emergency transportation for enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, the emergency transportation provider must submit a properly completed and coded claim form for emergency transport, which includes an appropriate ICD-9-CM diagnosis code as described in Medicaid Policy.

(e) Emergency Professional Services
The Contractor must provide professional services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard. The Contractor acknowledges that hospitals offering emergency services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. The Contractor further acknowledges that if an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the enrollee.

(f) Emergency Facility Services
The Contractor must ensure that emergency services continue until the enrollee is stabilized and can be safely discharged or transferred. If an enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services. However, such services shall be deemed prior authorized if the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) for responding to a request for authorization being made by the emergency department.

(3) Out-of-Network Services
The Contractor must reimburse out-of-network providers for covered services if the service was medically necessary, authorized by the Contractor, and could not reasonably be obtained by a network provider, inside or outside the State of Michigan, on a timely basis. Covered services are considered authorized if the Contractor does not respond to a request for authorization within 24 hours of the request (authorization for emergent services is covered under Section 1.022(F)(1)(c)). This provision applies to out-of-network providers inside and outside the State of Michigan.

The Contractor must comply with Medicaid Policy regarding requirements for authorization and reimbursement for out-of-network providers. Out-of-network claims must be paid at established Medicaid fees in effect on the date of service for paying participating Medicaid providers as established by Medicaid Policy. If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid Policy for the determination of the correct payment amount.

(4) Family Planning Services
Family planning services include any medically approved diagnostic evaluation, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of STDs. Services are to be provided in a confidential manner to individuals of childbearing age including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or wish to limit the number and spacing of their children.

The Contractor must:

(a) Ensure that enrollees have full freedom of choice of family planning providers, both in-network and out-of-network
(b) Encourage the use of public providers in their network
(c) Pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service, at established Medicaid FFS fees in effect on the date of service paid to participating Medicaid providers
(d) Encourage family planning providers to communicate with PCPs once any form of medical treatment is undertaken

(e) Maintain accessibility for family planning services through promptness in scheduling appointments, particularly for teenagers
(f) Make certain that Medicaid funding is not utilized for services for the treatment of infertility

(5) Federally Qualified Health Centers (FQHCs)
The Contractor must provide enrollees with access to services provided through an FQHC if the enrollee resides in the county in which the FQHC is located and if the enrollee requests such services. The Contractor must inform enrollees of this right in their member handbooks.

If a Contractor has an FQHC in its provider network in the county and allows members to receive medically necessary services from the FQHC, the Contractor has fulfilled its responsibility to provide FQHC services and does not need to allow enrollees to access FQHC services out-of-network.

If a Contractor does not include an FQHC in the provider network in the county and an FQHC exists in the service area (county), the Contractor must allow enrollees to receive services from the out-of-network FQHCs. FQHC services must be prior authorized by the Contractor; however, the Contractor may not refuse to authorize medically necessary services if the Contractor does not have an FQHC in the network for the service area (county). The Social Security Act requires that Contractors pay the FQHCs at least as much as the Contractor pays to a non-FQHC provider for the same service. Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs.

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

(6) Co-Payments
The Contractor may require co-payments by enrollees, consistent with State and federal guidelines, Medicaid Policy, waivers obtained by DCH, and other DCH requirements. The Contractor must not implement co-payments without DCH approval. Enrollees must be informed of co-payments during the open enrollment period. Co-payment requirements must be listed in the member handbook. The Contractor must meet lock-in and notification requirements in order to implement co-payments outside of the annual open enrollment period.

No provider may deny services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

(7) Abortions
Medicaid funds cannot be used to pay for elective abortions and related services to terminate pregnancy unless one of the following conditions is met:

- A physician certifies that the abortion is medically necessary to save the life of the mother
- The pregnancy is a result of rape or incest
- Treatment is for medical complications occurring as a result of an elective abortion
- Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy

All appropriate forms relating to abortion must be completed by the designated party and the Contractor must retain these forms for seven years.

(8) Pharmacy
The Contractor may have a prescription drug management program that includes a drug formulary. DCH may review the Contractor's formularies regularly, particularly if enrollee complaints regarding access have been filed regarding the formulary. The Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug that is covered under the Medicaid FFS program.

Drug coverages must include over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin, as covered by the Medicaid FFS program. Condoms must also be made available to all eligible enrollees.

(b) Pharmacy Carve Out
The Contractor is not responsible for: (i) anti-psychotic classes and the H7Z class psychotropic drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out" at www.Michigan.fhsc.com;

(ii) drugs in the anti-retroviral classes, as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out at www.Michigan.fhsc.com, including protease inhibitors and reverse transcriptase inhibitors; (iii) substance abuse treatment drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve Out at www.Michigan.fhsc.com. These medications are reimbursed by DCH's pharmacy third party administrator (TPA) through a point-of-service reimbursement system.

(c) Other Psychotropic Pharmacy Services

The Contractor agrees to act as DCH's TPA and reimburse pharmacies for psychotropic drugs not listed in the drug classifications specified above. In the performance of this function:

v. The Contractor must follow Medicaid FFS utilization controls for Medicaid psychotropic prescriptions. The Contractor must follow Medicaid FFS policy for prior authorization on all psychotropic medications
vi. The Contractor agrees that it and its pharmacy benefit managers are precluded from billing manufacturer rebates on psychotropic drugs
vii. The Contractor agrees to provide payment files to DCH in the format and manner prescribed by DCH available at www.michigan.fhsc.com/Documents
viii. DCH agrees to use the payment files to reimburse the Contractor for 60% of the Medicaid fee according to the Medicaid pharmaceutical reimbursement policy
ix. The Contractor is responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for enrollees but may limit access to contracted lab and x-ray providers

(9) Well Child Care/Early and Periodic Screening, Diagnosis and Treatment Program

Well Child/EPSDT is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. It supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources. The Contractor agrees to provide the Well Child/EPSDT services as delineated in the EPSDT section of the Practitioner Chapter in the Medicaid Provider Manual.

As specified in federal regulations, the screening component includes a general health screening most commonly known as a periodic Well Child/EPSDT examination. The required Well Child/EPSDT screening guidelines, based on the American Academy of Pediatrics' (AAP) recommendations for preventive pediatric health care, include:

- Health and developmental history
- Height and weight measurements and age appropriate head circumference
- Blood pressure for children 3 and over
- Age appropriate unclothed physical examination
- Age appropriate screening, testing and vaccinations
- Immunization review and administration
- Blood lead testing for children under 6 years of age
- Developmental/behavioral assessment
- Nutritional assessment
- Hearing, vision and dental assessments
- Health education including anticipatory guidance
- Interpretive conference and appropriate counseling for parents or guardians

Additionally, objective developmental/behavioral, hearing, and vision screening and testing must be performed in accordance with the Medicaid Policy and periodicity schedule. Laboratory services for hematocrit, hemoglobin, urinalysis, hereditary/metabolic, or other needed testing as determined by the physician must be provided.

The Contractor must provide the following Well Child/EPSDT services:

- Vision services under Well Child/EPSDT must include at least diagnosis and treatment for defective vision, including glasses if appropriate
- Dental services under Well Child/EPSDT must include at least relief of pain and infections, restoration of teeth, and maintenance of dental health. (The Contractor is responsible for screening/ and referral only)
- Hearing services must include at least diagnosis and treatment for hearing defects, including hearing aids as appropriate

- Other health care, diagnostic services, treatment, or services covered under the State Medicaid Plan necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening
- A medically necessary service may be available under Well Child/EPSDT if listed in a federal statute as a potentially covered service, even if Michigan's Medicaid program does not cover the service under its State Plan for Medical Assistance Program

The Contractor must make appropriate referrals for diagnostic or treatment services determined to be necessary.

- Oral screening should be part of a physical exam; however, each child must have a direct referral to a dentist after age 2
- Children should also be referred to a hearing and speech clinic, optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services as necessary
- Referral to community mental health services also may be appropriate
- Children at high-risk should be tested according to American Academy of Pediatrics (AAP) guidelines. Problems found or suspected during a Well Child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health care or presenting need.

For example, if a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, then a referral should be made for follow-up services that may include an epidemiological investigation to determine the source of blood lead poisoning.

The Contractor must provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for Well Child/EPSDT visits. Outreach contacts may be by phone, home visit, or mail. The Contractor will meet this requirement by contracting with other organizations and non-profit agencies that have a demonstrated capacity of reaching the Well Child/EPSDT target population. The Contractor will obtain information from the contracted agencies regarding members who require Well Child/EPSDT services or are overdue for Well Child/EPSDT services. The Contractor will monitor services provided by the Contractor to these identified members to ensure that the members receive the required services.

(10) Immunizations

The Contractor must provide enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. Immunizations should be given in accordance with Medicaid Policy. The Contractor must encourage that all providers use vaccines available free under the Vaccine for Children (VFC) program for children 18 years old and younger available at no cost. For vaccines available through the VFC, when the immunization is obtained at a local health department, the Contractor is responsible for the reimbursement of administration fees regardless of prior authorization or the existence of a contract with the local health department.

For enrollees age 19 years of age or older, the Contractor is responsible for the reimbursement of administration fees for immunizations covered by Medicaid Policy that enrollees have obtained from local health departments at Medicaid-FFS rates. This policy is effective without Contractor prior authorization and regardless of whether a contract exists between the Contractor and the local health departments.

The Contractor must participate in the local and State immunization initiatives/programs. The Contractor must also educate and encourage provider participation with the Michigan Care Improvement Registry (MCIR).

(11) Transportation

When necessary, the Contractor must provide non-emergency transportation, including travel expenses, to authorized, covered services. The Contractor must provide, at a minimum, the services outlined in the DHS guidelines for the provision of non-emergency transportation including the provision of travel expenses, meals, and lodging. The Contractor must also utilize DHS guidelines for the evaluation of a member's request for medical transportation to maximize use of existing community resources. DCH will obtain and review Contractor's non-emergency transportation policies, procedures, and utilization information, upon request, to ensure this requirement is met.

The Contractor must provide medical transportation to receive any service covered by this Contract, including, but not limited to the following:

- Chronic and ongoing treatment
- Prescriptions

- Medical supplies
- Visits for medical care

The transportation benefit does not include transportation to services that are not covered under this Contract such as transportation to Women, Infant, and Children (WIC) services, dental office services, specialized CMHSP services or support, or transportation to substance abuse services.

(12) Transplant Services
The Contractor must cover all costs associated with transplant surgery and care. Related care may include, but is not limited to, organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs. Cornea and kidney transplants and related procedures are covered services. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, small bowel, and bone marrow including allogenic, autologous and peripheral stem cell harvesting) must be covered on a patient-specific basis when determined medically necessary according to currently accepted standards of care. The Contractor must have a process in place to evaluate, document, and act upon such requests.

(13) Communicable Disease Services
The Contractor agrees that enrollees may receive treatment services for communicable diseases from local health departments without prior authorization by the Contractor. For purposes of this Section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

To facilitate coordination and collaboration, the Contractor is encouraged to enter into agreements or contracts with local health departments. Such agreements or contracts should provide details regarding confidentiality, service coordination and instances when local health departments will provide direct care services for the Contractor's enrollees. Agreements should also discuss, where appropriate, reimbursement arrangements between the Contractor and the local health department.

If a local agreement is not in effect and an enrollee receives services for a communicable disease from a local health department, the Contractor is responsible for payment to the local health department at established Medicaid-FFS rates in effect on the date of service.

(14) Restorative Health Services
Restorative health services means intermittent or short-term "restorative" or rehabilitative nursing care that may be provided in or out of licensed nursing facilities. The Contractor is responsible for providing up to 45 days (within a rolling 12 month period from initial admission) of intermittent or short-term restorative or rehabilitative services in a nursing facility as long as medically necessary and appropriate for enrollees. The 45-day maximum does not apply to restorative health services provided in places of service other than a nursing facility.

The Contractor is expected to help facilitate support services such as home help services that are not the direct responsibility of the Contractor but are services to which enrollees may be entitled. Such care coordination should be provided consistent with the individual or person-centered planning that is necessary for enrollee members with special health care needs.

(15) Child and Adolescent Health Centers and Programs
The Contractor acknowledges that enrollees may choose to obtain covered services from a Child and Adolescent Health Centers and Programs (CAHCPs) provider without prior authorization from the Contractor. If the CAHCP does not have a contractual relationship with the Contractor, then the Contractor is responsible for payment to the CAHCP at Medicaid FFS rates in effect on the date of service.

The Contractor may contract with a CAHCP to deliver covered services as part of the Contractor's network. If the CAHCP is in the Contractor's network, the following conditions apply:

(a) Covered services must be medically necessary and administered by or arranged by a designated PCP
(b) The CAHCP will meet the Contractor's written credentialing and re-credentialing policies and procedures for ensuring quality of care and ensuring that all providers rendering services to enrollees are licensed by the State and practice within their scope of practice as defined for them in Michigan's Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211
(c) The Contractor must reimburse the CAHCP according to the provisions of the contractual agreement

(16) Hospice Services

The Contractor is responsible for all medically necessary and authorized hospice services, including the "room and board" component of the hospice benefit when provided in a nursing home or hospital. Members who have elected the hospice benefit will not be disenrolled after 45 days in a nursing home as otherwise permitted under Section 1.022(F)(13).

(17) Twenty Visit Mental Health Outpatient Benefit

The Contractor must provide a maximum of 20 outpatient mental health visits within a calendar year consistent with the policy and procedures established by Medicaid Policy. Services may be provided through contracts with Community Mental Health Services Programs (CMHSP), Pre-paid Inpatient Hospital Plans (PIHPs), or through contracts with other appropriate providers within the service area.

(18) Persons with Special Health Care Needs

The Contractor is required to do the following for members identified by DCH as persons with special health care needs:

(a) Conduct an assessment in order to identify any special conditions of the enrollee that require ongoing case management services
(b) Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs
(c) For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the enrollee

(19) Case Management/Disease Management

Case management is a coordination of care and services provided to members needing extended use of resources and help navigating the system of care. Disease management is a proactive multidisciplinary process and approach to identify populations with, or at risk for chronic medical conditions. The Contractor agrees to provide case management/disease management and coordination services. These services must be operationally integrated into the Contractor's utilization management and enrollee services.

The Contractor will demonstrate a commitment to case managing the complex health care needs of enrollees. The Contractor will support the physician-patient relationship in the plan of care and prevention of exacerbation and complications. The Contractor will take into account all of an enrollee's needs (e.g. home health services, therapies, durable medical equipment and transportation).

(20) Pregnant Women

Special conditions apply to new enrollees in the Contractor's health plan who are pregnant at the time of enrollment. These enrollees must be allowed to select or remain with the Medicaid obstetrician of her choice and are entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from the health plan. The services may be provided without preauthorization regardless of whether the provider is a contracted network provider. In the event that the Contractor does not have a contract with the provider, all claims should be paid at the Medicaid FFS rate.

(21) Tobacco Cessation Treatment

The Contractor must provide covered tobacco cessation treatment that includes, at a minimum, the following services:

(f) Intensive tobacco use treatment through a DCH approved telephone quit line
(g) Over-the-counter agents (patch and also gum or lozenge) used to promote smoking cessation
(h) One prescription of non-nicotine medication used to promote smoking cessation

The Contractor may place a reasonable limit on the type and frequency of over-the-counter and prescription agents covered under this benefit. The Contractor may also require prior authorization for prescription drugs. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

G. Inclusion

DCH considers inclusion of enrollees into the broader health delivery system to be important. The Contractor must have written guidelines and a process in place to ensure that enrollees are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. In addition, the Contractor must ensure that:

(a) Enrollees will not be denied a covered service or availability of a facility or provider identified in this Contract
(b) Network providers will not intentionally segregate enrollees in any way from other persons receiving health care services

H. Enrollee Services

(1) General

Written and oral materials directed to enrollees relating in any fashion to benefits, coverage, enrollment, grievances, appeals, or other administrative and service functions, such as handbooks, newsletters, and other member enrollment materials must be approved by DCH prior to distribution to enrollees. Once DCH approves a letter template, the Contractor may reuse the template without obtaining additional approval. These materials must be written no higher than a 6.9 grade reading level. Upon receipt by DCH of a complete request for approval of the proposed communication, DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. All enrollee services must address the need for culturally appropriate interventions. Reasonable accommodation must be made for enrollees with hearing and/or vision impairments.

Written and oral materials directed to enrollees relating solely to health education may be filed with DCH a minimum of 10 business days prior to use. If DCH does not respond to the filing within 10 business days the material is deemed approved.

The Contractor must establish and maintain a toll-free 24 hours per day, 7 days per week telephone number to assist enrollees. Direct contact with a qualified clinical staff person or network provider must be available through a toll-free telephone number at all times.

The Contractor must issue to all enrollees an eligibility card that includes the toll-free 24 hours per day, 7 days per week phone number for enrollees to call and a unique identifying number for the enrollee. The card must also identify the member's PCP name and phone number. The Contractor may meet this requirement in one of the following ways:

(a) Print the PCP name and phone number on the card. The Contractor must send a new card to the enrollee when the PCP assignment changes
(b) Print the PCP name and phone number on a replaceable sticker to be attached to the card. The Contractor must send a new sticker to the enrollee when the PCP assignment changes
(c) Any other method approved by DCH, provided that the PCP name and phone number is affixed to the card and the information changes when the PCP assignment changes
(d) The Contractor may submit a weekly PCP Submission Update File that includes all PCP changes and additions made by the Contractor during that week. If the Contractor submits an update file each week, the Contractor is not required to include the member's PCP name and phone number on the member identification card

(2) Enrollee Education

The Contractor is responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the Contractor's services. Materials for enrollee education should include:

(b) Member handbook
(c) Contractor bulletins or newsletters sent to the Contractor's enrollees at least two times a year that provide updates related to covered services, access to providers and updated policies and procedures
(d) Literature regarding health/wellness promotion programs offered by the Contractor
(e) A website, maintained by the Contractor, that includes information on preventive health strategies, health/wellness promotion programs offered by the Contractor, updates related to covered services, access to providers, complete provider directory, and updated policies and procedures

Enrollee education should also focus on the appropriate use of health services and prevention of fraud, waste, and abuse. The Contractor is encouraged to work with local and community based organizations to facilitate their provision of enrollee education services.

(3) Member Materials

(a) General

The Contractor must mail the member ID card to enrollees via first class mail within 10 business days of being notified of the enrollee's enrollment. All other printed information, including member handbook and information regarding accessing services may be mailed separately from the ID card. These materials need not be mailed via first class but must be mailed within 10 business days of being notified of the member's enrollment.

The Contractor may distribute new member packets to each household instead of to each individual member in the household, provided that the mailing includes individual health plan membership cards for each member enrolled in the household. When there are program or service site changes, notification must be provided to the affected enrollees at least 10 business days before implementation.

The Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least once a year and updated when necessary. The provider directory may be published separately.

(b) Member Handbook

The handbook must be written at no higher than a 6.9 grade reading level and must be available in alternative formats for enrollees with special needs. Member handbooks must be available in a prevalent language when more than 5% of the Contractor's enrollees speak a prevalent language, as defined by the Contract. The Contractor must also provide a mechanism for enrollees who speak the prevalent language to obtain member materials in the prevalent language and a mechanism for enrollees to obtain assistance with interpretation. The Contractor must agree to make modifications in the handbook language to comply with the specifications of this Contract.

At a minimum, the member handbook must include the following information:

iv. Table of contents
v. Advance directives, including, at a minimum: (1) information about the Contractor's advance directives policy, (2) information regarding the State's advance directives provisions and (3) directions on how to file a complaint with the State concerning noncompliance with the advance directive requirements. Any changes in the State law must be updated in this written information no later than 90 days following the effective date of the change
vi. Availability and process for accessing covered services that are not the responsibility of the Contractor, but are available to its enrollees, such as dental care, behavioral health, and developmental disability services
vii. Description of all available Contract services
viii. Designation of specialists as a PCP
ix. Enrollees' rights and responsibilities. The enrollee rights information must include a statement that conveys that Contractor staff and affiliated providers will comply with all requirements concerning enrollee rights
x. Enrollees' right to obtain routine OB/GYN and pediatric services from network providers without a referral
xi. Enrollees' right to receive FQHC services
xii. Enrollees' right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
xiii. Explanation of any service limitations or exclusions from coverage
xiv. Fair Hearing process including that access may occur without first going through the Contractor's grievance/appeal process
xv. Grievance and appeal process including how to register a grievance with the Contractor and the State, how to file a written appeal, and the deadlines for filing an appeal and an expedited appeal
xvi. How enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior
xvii. How to access hospice services
xviii. How to choose and change PCPs
xix. How to contact the Contractor's Member Services and a description of its function
xx. How to access out-of-county and out-of-state services
xxi. How to make, change, and cancel appointments with a PCP
xxii. How to obtain emergency transportation and medically necessary transportation
xxiii. How to obtain medically necessary durable medical equipment (or customized durable medical equipment)

xxiv. How to obtain oral interpretation services and written information in prevalent languages, as defined by the Contract
xxv. How to obtain written materials in alternative formats for enrollees with special needs
xxvi. Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant
xxvii. Process of referral to specialists and other providers
xxviii. Signs of substance abuse problems, available substance abuse services and accessing substance abuse services
xxix. Vision services, family planning services, and how to access these services
xxx. Well Child care, immunizations, and follow-up services for enrollees under age 21 (EPSDT)
xxxi. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations
xxxii. What to do when family size changes
xxxiii. WIC Supplemental Food and Nutrition Program
xxxiv. Any other information deemed essential by the Contractor and/or DCH

(c) Provider Directory

The Contractor must maintain a complete provider directory on the Contractor's web site; the Contractor is not required to a mail provider directory to all new enrollees. The web provider directory must be reviewed for accuracy and updated at least monthly. The Contractor must inform new enrollees that the provider directory is available upon request and on the Contractor's web site and must mail the provider directory within five business days of the enrollee's request.

The Contractor must maintain a provider directory that contains, at a minimum, the following information:

i. PCPs and specialists listed by county
ii. For PCP listings, the following information must be provided: provider name, address, telephone number, any hospital affiliation, whether the provider is accepting new patients, and languages spoken. Additionally, the Contractor must maintain full compliance with the office hour information on the 4275 provider file or the Contractor must list days and hours of operation on the PCP listing in the provider directory
iii. For specialist listings, the following information must be provided: Provider name, address, telephone number, and any hospital affiliation
iv. A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers the enrollees may need to access. The list must contain the address and phone number of the provider. Ancillary providers that are part of a retail chain may be listed by the name of the chain without listing each specific site

I. Grievance and Appeal Policies and Procedures

(8) Contractor Grievance/Appeal Policy and Procedures Requirements

The Contractor must establish and maintain an internal process for the resolution of grievances and appeals from enrollees. Enrollees may file a grievance or appeal on any aspect of covered services as specified in the definitions of grievance and appeal.

The Contractor must have written policies and procedures governing the resolution of grievances and appeals. DCH must approve the Contractor's grievance and appeal policies prior to implementation. These written policies and procedures will meet the following requirements:

(e) Except as specifically exempted in this Section, the Contractor must administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F)
(f) The Contractor must cooperate with the Michigan Office of Financial and Insurance Regulation (OFIR) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act"
(g) The Contractor must make a decision on non-expedited grievances or appeals within 35 calendar days of receipt of the grievance or appeal. This timeframe may be extended up to 10 business days if the enrollee requests an extension or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the enrollee's interest. If the Contractor utilizes the extension, the Contractor must give the enrollee written notice of the reason for the delay. The Contractor may not toll (suspend) the time frame for grievance or appeal decisions other than as described in this Section

(h) If a grievance or appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the beneficiary, the 35-day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the beneficiary that an authorized representative form or document is required. For purposes of this Section "third party" includes, but is not limited to, health care providers

(i) The Contractor's internal grievance and appeal procedure must include the following components:

i. The Contractor must allow enrollees 90 days from the date of the adverse action notice within which to file an appeal under the Contractor's internal grievance and appeal procedure

ii. The Contractor must give enrollees assistance in completing forms and taking other procedural steps. The Contractor must provide interpreter services and TTY/TDD toll-free numbers

iii. The Contractor must acknowledge receipt of each grievance and appeal

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

- Not involved in any previous level of review or decision-making and
- Health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease when the grievance or appeal involves a clinical issue

(9) Notice to Enrollees of Grievance Procedure

The Contractor must inform enrollees about the Contractor's internal grievance procedures at the time of initial enrollment and any other time an enrollee expresses dissatisfaction by filing a grievance with the Contractor. The information will be included in the member handbook and will explain:

(c) How to file a grievance with the Contractor

(d) The internal grievance resolution process

(10) Notice to Enrollees of Appeal Procedure

The Contractor must inform enrollees about the Contractor's appeal procedure at the time of initial enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to appeal under the definition of appeal in this Contract. The information will be included in the member handbook and will explain:

(d) How to file an appeal with the Contractor

(e) The internal appeal process

(f) The member's right to a Fair Hearing with the State

When the Contractor makes a decision subject to appeal, as defined in this Contract, the Contractor must provide a written adverse action notice to the enrollee and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services must be made at least 12 days prior to the change in services.

(11) Adverse Action Notice

Adverse action notices involving service authorization decisions that deny or limit services must be made within the time frames described in Section 1.022(AA) of this Contract. The notice must include the following components:

(h) The action the Contractor or Subcontractor has taken or intends to take

(i) The reasons for the action

(j) The enrollee's or provider's right to file an appeal

(k) An explanation of the Contractor's appeal process

(l) The enrollee's right to request a Fair Hearing

(m) The circumstances under which expedited resolution is available and how to request it

(n) 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

(12) State Medicaid Appeal Process

The State will maintain a Fair Hearing process to ensure that enrollees have the opportunity to appeal decisions directly to the State. The Contractor must include the Fair Hearing process as part of the written internal process for resolution of appeals and must describe the Fair Hearing process in the member handbook.

(13) Expedited Appeal Process

The Contractor's written policies and procedures governing the resolution of appeals must include provisions for the resolution of expedited appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:

(g) The enrollee or provider may file an expedited appeal either orally or in writing
(h) The enrollee or provider must file a request for an expedited appeal within 10 days of the adverse determination
(i) The Contractor must make a decision on the expedited appeal within 72 hours of receipt of the expedited appeal. If the enrollee requests an extension, the Contractor should transfer the appeal to the standard 35-day time frame and give the enrollee written notice of the transfer within 2 days of the extension request
(j) The Contractor must give the enrollee oral and written notice of the appeal review decision
(k) If the Contractor denies the request for an expedited appeal, the Contractor must transfer the appeal to the standard 35-day timeframe and give the enrollee written notice of the denial within 2 days of the expedited appeal request
(l) The Contractor must not take any punitive actions toward a provider who requests or supports an expedited appeal on behalf of an enrollee

J. Confidentiality

All enrollee information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by the Contractor from unauthorized disclosure. The Contractor must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with its administration of the Contract.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services.

K. Accreditation/Certification Requirements

(1) The Contractor must hold and maintain accreditation as a managed care organization by the NCQA or URAC Accreditation for Health Plans
(2) The Contractor must be incorporated within the State of Michigan and have a Certificate of Authority to operate as a Health Maintenance Organization (HMO) in the State of Michigan in accordance with MCL 500.3505

L. Observance of Federal, State and Local Laws

The Contractor agrees that it will comply with all current State and federal statutes, regulations, and administrative procedures including, but not limited to, Equal Employment Opportunity Provisions, Right to Inventions, Clean Air Act, and Federal Water Pollution Control Act, and Byrd Anti-Lobbying Amendment. The Contractor agrees that it will comply with all current State and federal statutes, regulations, and administrative procedures that become effective during the term of this Contract. Federal regulations governing contracts with risk based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract. The State is not precluded from implementing any changes in State or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Contract Section 2.024.

(1) Special Waiver Provisions for CHCP

CMS has granted DCH a waiver under Section 1915(b)(1)(2) of the Social Security Act, granting the State a waiver of section 1902 (a)(23) of the Social Security Act. Under this waiver, beneficiaries will be enrolled with a Contractor in the county of their residence. All health care for enrollees will be arranged for or administered only by the Contractor. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this Contract.

(2) Fiscal Soundness of the Risk-Based Contractor

Federal regulations (42 CFR 438.116) require that the risk-based Contractors maintain a fiscally solvent operation. To this end, the Contractor must comply with all HMO statutory requirements for fiscal soundness and DCH will evaluate the Contractor's financial soundness based upon the thresholds established in Appendix 2 of this Contract. If the Contractor does not maintain the minimum statutory financial requirements, DCH will apply remedies and sanctions according to Section 1.022(EE) of this Contract, including termination of the Contract. The Contractor must maintain financial records for its Medicaid activities separate from other financial records.

(3) Prohibited Affiliations with Individuals Debarred by Federal Agencies

The following individuals are covered under this Section:

(d) Providers – All contracted providers

(e) Provider employees – Directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity

(f) Contractor employees – Director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the entity's equity

Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. An enrollee may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds may be used. DCH publishes a list of providers who are terminated, suspended, or otherwise excluded from participation in the program. The Contractor must ensure that its provider networks do not include these providers.

Pursuant to Section 42 CFR 438.610, a Contractor may not knowingly have a director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the entity's equity who is currently debarred or suspended by any state or federal agency. The Contractor is also prohibited from having a contractual, employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State.

The review for individuals that are debarred or suspended by any state or federal agency must be performed when the Contractor initiates employment or provider enrollment. The Contractor must have procedures for the regular review of covered individuals to ensure that none become debarred or suspended by any state or federal agency during the course of employment or contractual relationship. The initial and periodic reviews must also require covered individuals to disclose criminal convictions related to federal healthcare programs.

The United States General Services Administration (GSA) also maintains a list of parties excluded from federal programs. The Excluded Parties Listing System (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's homepage at the following Internet address: www.epls.gov.

(4) Public Health Reporting

State law requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The Contractor must require compliance with all such reporting requirements in its provider contracts.

(5) Compliance with CMS Regulation

The Contractor is required to comply with all CMS regulations, including, but not limited to, the following:

- Enrollment and disenrollment: As required by 42 CFR 438.56, the Contractor must meet all the requirements specified for enrollment and disenrollment limitations
- Provision of covered services: As required by 42 CFR 438.102(a)(2), the Contractor is required to provide all covered services listed in **Section 1.022(E) and 1.022(F)** of the Contract. A Contractor electing to withhold coverage as allowed under this provision must comply with all notification requirements

(6) Compliance with Health Insurance Portability and Accountability Act Regulation

The Contractor must comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.

(7) Advanced Directives Compliance

The Contractor must comply with all provisions for advance directives (described in 42 CFR 422.128) as required under 42 CFR 438.6. The Contractor must have in effect, written policies and procedures for the use and handling of advance directives written for any adult individual receiving medical care by or through the Contractor. The policies and procedures must include at least the following provisions:

- The enrollee's right to have and exercise advance directives under the law of the State of Michigan, (MCL 700.5506-700.5512 and MCL 333.1051-333.1064)
- Changes to laws pertaining to advanced directives must be updated in the policies no later than 90 days after the changes occur, if applicable
- The Contractor's procedures for respecting advanced directives rights, including any limitations if applicable

(8) Medicaid Policy

As required, the Contractor must comply with provisions of Medicaid Policy applicable to MHPs developed under the formal policy consultation process, as established by the Medical Assistance Program unless provisions of this Contract stipulate otherwise.

(9) Compliance with False Claims Acts

The Contractor must comply with all applicable provisions of the federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and State laws specifically include, but are not limited to, the following:

(a) Establish and disseminate written policies for employees of the entity (including managing employees) and any contractor or agent of the entity regarding the detection and prevention of waste, fraud, and abuse
(b) The written policies must include detailed information about the federal False Claim Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act
(c) The written policies must specify the rights of employees to be protected as whistleblowers
(d) The written policies must also be adopted by the Contractor's contractors or agents. A "contractor" or "agent" includes any contractor, Subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity
(e) If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees regarding detection and prevention of fraud, waste and abuse including an explanation of the false claims acts and of the rights of employees to be protected as whistleblowers

(10) Protection of Enrollees against Liability for Payment and Balanced Billing

Section 1932(b)(6) of the Social Security Act requires Contractors to protect enrollees from certain payment liabilities. Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to providers in the case of services provided to an individual enrolled with a Contractor who charge at a rate in excess of the rate permitted under the organization's Contract.

M. Disclosure of Physician Incentive Plan

The Contractor must disclose to DCH, upon request, the information on their provider incentive plans listed in 42 CFR 422.208 and 422.210, as required in 42 CFR 438.6(h). The incentive plans must meet the requirements of 42 CFR 422.208-422.210 when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903(s) of the Social Security Act. Upon request, the Contractor must provide the information on its physician incentive plans listed in 42 CFR 422.208 and 422.210 to any enrollee.

N. Policies, Procedures and Operational Plans

(2) General

The Contractor must develop and maintain the following written policies, procedures and operational plans:

(a) Policies, procedures and an operational plan for management information systems
(b) Procedures to review and authorize all network provider contracts
(c) Policies and procedures for credentialing and monitoring credentials of all healthcare personnel
(d) Policies and procedures for providing education to employees, providers and members on identifying, addressing, and reporting instances of fraud, waste, and abuse
(e) Procedures to review and authorize contracts established for reinsurance and third party liability if applicable
(f) Policies to ensure compliance with all federal and State business requirements

(3) Availability upon Request

All policies, procedures, operational plans, and clinical guidelines that the Contractor follows must be in writing and available to DCH and CMS upon request. All medical records, reporting formats, information systems, liability policies, provider network information and other detail specific to performing the contracted services must be available to DCH and CMS upon request.

O. Program Integrity

(2) General

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan. The Contractor's arrangements or procedures must include the following as defined in 42 CFR 438.608:

(a) Written policies and procedures that describes how the Contractor will comply with federal and State fraud, waste, and abuse standards
(b) The designation of a compliance officer who is accountable to the senior management or Board of Directors and who has effective lines of communication to the Contractor's employees
(c) Effective training and education for the compliance officer and the Contractor's employees
(d) Provisions for internal monitoring and auditing
(e) Provisions for prompt response to detected offenses and for the development of corrective action initiatives
(f) Documentation of the Contractor's enforcement of federal and State fraud and abuse standards
(g) Provision of the contact information (addresses and toll-free telephone numbers) for both the Contractor and the Medicaid Integrity Program (MIP) to their employees, members, and provider annually. The Contractor must indicate that reporting may be made anonymously

A Contractor who has any suspicion or knowledge of fraud and/or abuse within any of DCH's programs must report directly to MIP by calling (866) 428-0005 or sending a memo or letter to:

Medicaid Integrity Program Section
Capitol Commons Center Building, 6th floor
P.O. Box 30479
400 S. Pine Street
Lansing, Michigan 48909-7979

The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the enrollees receiving services. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution at the annual site visit.

(3) Reporting
The Contractor must report all (employee, providers and members) suspected fraud and/or abuse that warrant investigation to DCH Medicaid Integrity Program.

Additionally, the Contractor must provide the number of complaints warranting a preliminary investigation each year. Further, for each complaint warranting full investigation, the Contractor must provide to DCH Medicaid Integrity Program the following information:

- The name of the provider, individuals, and/or entity, including their address, phone number and Medicaid identification number, and any other identifying information
- Source of the complaint
- Type of provider
- Nature of the complaint
- Approximate range of dollars involved
- Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred

The Contractor must inform DCH of actions taken to investigate or resolve the reported suspicion, knowledge, or action. The Contractor must also cooperate fully in any investigation by DCH or the Department of Attorney General and any subsequent legal action that may result from such investigation.

The Contractor is permitted to disclose protected health information to DCH or the Department of Attorney General without first obtaining authorization from the enrollee to disclose such information. DCH and the Department of Attorney General shall ensure that such disclosures meet the requirements for disclosures made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.501.

P. Management Information Systems
(2) MIS Capability
The Contractor must maintain a management information system that collects, analyzes, integrates, and reports data as required by DCH. The information system must have the capability for:
(g) Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by DCH through an encounter data system
(h) Supporting provider payments and data reporting between the Contractor and DCH
(i) Controlling, processing, and paying providers for services rendered to Contractor enrollees

(j) Collecting service-specific procedures and diagnosis data, collecting price-specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintaining detailed records of remittances to providers

(k) Supporting all Contractor operations, including, but not limited to, the following:

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

viii. Utilization

ix. Provider enrollment

x. Third party liability activity

xi. Claims payment

xii. Grievance and appeal tracking

xiii. Tracking and recall for immunizations, Well Child/EPSDT, and other services as required by DCH

xiv. Encounter reporting

xv. Quality reporting

xvi. Member access and satisfaction

(3) Enrollment Files

DCH will provide HIPAA compliant weekly and monthly enrollment files to the Contractor via the Data Exchange Gateway (DEG). The Contractor's MIS must have the capability to utilize the files to update each enrollee's status on the MIS. The Contractor is required to load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's vendors (i.e. pharmacy, vision, behavioral health, DME) on or before the first of the month so that enrollees have access to services. Enrollees defined as "pending negative action" on the audit file should be reflected as enrolled on the Contractor's system until the monthly update file is received. After the receipt of the monthly update file, enrollees designated as "pending negative action" on the audit file who have lost eligibility or enrollment may be terminated on the Contractor's MIS. The Contractor must ensure that MIS support staff have sufficient training and experience to manage files DCH sends to the Contractor via the DEG.

(4) Data Accuracy

The Contractor must ensure that data received from providers is accurate and complete by:

(a) Verifying the accuracy and timeliness of the data

(b) Screening the data for completeness, logic, and consistency

(c) Collecting service information in standardized formats

(d) Identifying and tracking fraud and abuse

(5) Automated Contract Tracking System

The Contractor is required to utilize the Department's Automated Contact Tracking System to submit the following requests:

(f) Disenrollment requests for out of area members who still appear in the wrong county on the Contractor's enrollment file

(g) Request for newborn enrollment for out of state births or births for which DCH does not notify the Contractor of the newborn's enrollment within two months of the birth

(h) Maternity Case Rate (MCR) Invoice Generation request for births for which the Contractor has not received an MCR payment within three months of the birth

(i) Other administrative requests required by DCH

Q. Provider Services (In-Network and Out-of-Network)

The Contractor must:

(1) Provide contract and education services for the provider network, including education regarding fraud and abuse

(2) Properly maintain medical records

(3) Process provider grievances and appeals in accordance with contract and regulatory requirements

(4) Develop and maintain an appeal system to resolve claim and authorization disputes

(5) Maintain a written plan detailing methods of provider recruitment and education regarding Contractor policies and procedures

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

(7) Provide a staff of sufficient size to respond timely to provider inquiries, questions, and concerns regarding covered services

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

(9) Make its provider policies, procedures and appeal processes available over its website. Updates to the policies and procedures must be available on the website as well as through other media used by the Contractor

R. Provider Network and Health Service Delivery Criteria

(1) General

The Contractor must maintain a network of qualified providers in sufficient numbers and locations within the counties in the service area, including counties contiguous to the Contractor's service area, to provide required access to covered services. The Contractor must also provide or arrange accessible care 24 hours per day, 7 days per week to the enrolled population. The Contractor is solely responsible for arranging and administering covered services to enrollees. Covered services must be medically necessary and administered, or arranged for, by a designated PCP. The Contractor must demonstrate that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of the enrollees within each enrollment area. The delivery system (in- and out-of-network) must include sufficient numbers of providers with the training, experience, and specialization to furnish the covered services listed in **Sections 1.022(E) and 1.022(F)** of this Contract to all enrollees.

Enrollees must be provided with an opportunity to select their PCP. If the enrollee does not choose a PCP at the time of enrollment, it is the Contractor's responsibility to assign a PCP within one month of the effective date of enrollment. If the Contractor cannot honor the enrollee's choice of the PCP, the Contractor must contact the enrollee to allow the enrollee to either make a choice of an alternative PCP or to disenroll (in counties not covered by the rural area exception). The Contractor must notify all enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.

Enrollees must be provided with an opportunity to change their PCP. The Contractor may not place restrictions on the number of times an enrollee can change PCPs with cause. However, the Contractor may establish a policy that restricts enrollees to PCP changes without cause. The Contractor must receive approval for this policy from DCH.

(2) Network Requirements

The Contractor's provider network must meet the following requirements:

(a) Maintains a PCP-to-enrollee ratio of at least one full-time PCP per 750 members. DCH will use this ratio to determine maximum enrollment capacity for the Contractor in an approved service area. Exceptions to the standard may be granted by DCH on a case-by-case basis, for example in rural counties

(b) Provides available, accessible, and sufficient numbers of facilities, locations, and personnel for the provision of covered services with sufficient numbers of provider locations with provisions for physical access for enrollees with physical disabilities; such locations must be located within the counties in the Contractor's service area, including counties contiguous to the Contractor's service area, to the extent available in the provider community

(c) Has sufficient capacity to handle the maximum number of enrollees specified under this Contract

(d) Guarantees that emergency services are available 24 hours per day, 7 days per week

(e) Provides access to specialists based on the availability and distribution of such specialists. The Contractor's provider network must include specialists within the counties in the Contractor's service area, including counties contiguous to the Contractor's service area, to the extent available in the provider community. If the Contractor's provider network does not have a provider available for a second opinion within the network, the enrollee must be allowed to obtain a second opinion from an out-of-network provider with prior authorization from the Contractor at no cost to the enrollee

(f) Provides access to ancillary services such as pharmacy services, durable medical equipment services, home health services, and MIHP

(g) Utilizes arrangements for laboratory services only through those laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates

(h) Contains only ancillary providers and facilities appropriately licensed or certified if required pursuant to the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211

(i) Responds to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the Medicaid population
(j) Selected PCPs are accessible taking into account travel time, availability of public transportation, and other factors that may determine accessibility
(k) Primary care services are available to enrollees within 30 miles or 30 minutes travel time. Hospital services are available within 30 miles or 30 minutes travel time. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 miles or 30 minutes travel time. For pharmacy services, DCH's expectations are that the Contractor will ensure access within 30 minutes travel time and that services will be available during evenings and on weekends
(l) Contracted PCPs provide or arrange for coverage of services 24 hours per day, 7 days per week
(m) PCPs must be available to see patients a minimum of 20 hours per practice location per week

(3) Provider Network File and PCP Submission File

Provider files will be used to give beneficiaries information on available Contractors and to ensure that the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation. The Contractor must comply with the following:

(a) Submit provider files that contain a complete and accurate description of the provider network available to enrollees according to the specifications and format delineated by DCH to DCH's Enrollment Services Contractor
(b) Update provider files as necessary to reflect the changes in the existing provider network
(c) Submit a provider file that passes all DCH quality edits to DCH's Enrollment Services Contractor at least once per month and more frequently if necessary to ensure that changes in the Contractor's provider network are reflected in the provider file in a timely manner

The Contractor must participate in the DCH file process for obtaining Contractor PCP data for dissemination to DCH eligibility and enrollment vendors. The Contractor must submit an initial complete file showing all PCP assignments for the current month prior to the implementation date of this process. Subsequently, the Contractor must submit PCP changes and additions at least once per month that DCH will send weekly to DCH eligibility and enrollment vendors. The Contractor may submit changes and additions each week.

S. Primary Care Provider (PCP) Standards

(1) PCP Choice

The Contractor must offer enrollees freedom of choice in selecting a PCP. The Contractor must have written policies and procedures describing how enrollees choose and are assigned to a PCP, and how they may change their PCP. The Contractor must permit enrollees to choose a clinic as a PCP provided that the provider files submitted to DCH's Enrollment Services Contractor is completed consistent with DCH requirements and the clinic has been approved by DCH to serve as a PCP.

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each enrollee's health care, and maintaining the enrollee's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, or pediatric physician when appropriate for an enrollee, other physician specialists when appropriate for an enrollee's health condition, nurse practitioners, and physician assistants.

The Contractor must allow a physician specialist to serve as a PCP when the enrollee's medical condition warrants management by a physician specialist. This may be necessary for those enrollees with conditions such as diabetes, end-stage renal disease, HIV/AIDS, or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the enrollee. If the enrollee disagrees with the Contractor's decision, the enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file a Fair Hearing Request with DCH.

(2) Access to Care 24 Hours per Day and 7 Days per Week

The Contractor must ensure that there is a reliable system for providing 24-hour access to urgent care and emergency services 7 days per week. All PCPs within the network must have information on this system and must reinforce with their enrollees the appropriate use of the health care delivery system. Routine physician and office visits must be available during regular and scheduled office hours. The Contractor must ensure that some

providers offer evening and weekend hours of operation in addition to scheduled daytime hours. The Contractor must provide notice to enrollees of the hours and locations of service for their assigned PCP.

Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the Contractor through other arrangements. Emergency services must always be available.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

(3) PCP Availability

The Contractor must assign a PCP who is within 30 miles or 30 minutes travel time to the enrollee's home, unless the enrollee chooses otherwise. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within 30 miles or 30 minutes travel time. The Contractor will take the availability of handicap accessible public transportation into consideration when making PCP assignments.

PCPs must be available to see enrollees a minimum of 20 hours per practice location per week. This provision may be waived by DCH in response to a request supported by appropriate documentation. Specialists are not required to meet this standard for minimum hours per practice location per week. In the event that a specialist is assigned to act as a PCP, the enrollee must be informed of the specialist's business hours. In circumstances where teaching hospitals use residents as providers in a clinic and a supervising physician is designated as the PCP by the Contractor, the supervising physician must be available at least 20 hours per practice location per week.

The Contractor must monitor waiting times to get appointments with providers, as well as the length of time actually spent waiting to see the provider. This data must be reported to DCH upon request. The Contractor must have established criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to DCH upon request.

(4) Maternity Care

The Contractor must ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and post-partum care. A maternity care provider is a provider meeting the Contractor's credentialing requirements and whose scope of practice includes maternity care. An individual provider must be named as the maternity care provider to assure continuity of care. An OB/GYN clinic or practice may be designated as a PCP or maternity care provider if chosen by the enrollee. Designation of a clinic or practice is appropriate as long as an individual provider, within the clinic or practice, agrees to accept responsibility for the enrollee's care for the duration of the pregnancy and post-partum care.

For maternity care, the Contractor must provide initial prenatal care appointments for enrolled pregnant women according to standards developed by the CAC and the Contractor's Quality Improvement Committee (QIC).

T. Network Changes

The Contractor must notify DCH within seven days of any changes to the composition of the provider network that affects the Contractor's ability to make available all covered services in a timely manner. The Contractor must have written procedures to address changes in its network negatively affecting access to care. Changes in provider network composition that DCH determines to negatively affect enrollees' access to covered services may be grounds for service area termination or sanctions, including Contract termination.

U. Provider Contracts

(1) Required Provisions

In addition to HMO licensure/certification requirements, Contractor provider contracts will meet the following criteria:

(a) Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles can be collected from enrollees. Co-payments are only permitted with DCH approval

(b) Require the provider to cooperate with the Contractor's quality improvement and utilization review activities

(c) Include provisions for the immediate transfer of enrollees to another Contractor PCP if their health or safety is in jeopardy
(d) Include provisions stating that providers are not prohibited from discussing treatment options with enrollees that may not reflect the Contractor's position or may not be covered by the Contractor
(e) Include provisions stating that providers are not prohibited from advocating on behalf of the enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services
(f) Require providers to meet Medicaid accessibility standards as defined in this Contract
(g) Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider
(h) If the plan utilizes co-payments for the covered service, prohibit the provider from denying services to an individual who is eligible for the services due to the individual's inability to pay the co-payment

(2) Provider Participation

In accordance with Section 1932(b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Contractors may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision also does not interfere with measures established by the Contractor that are designed to maintain quality and control costs consistent with the responsibility of the organization.

V. Provider Credentialing

The Contractor must comply with the requirements of MCL 500.3528 regarding the credentialing and re-credentialing of providers within the Contractor's network, including, but not limited to the requirements specified in this Section.

(1) Credentialing

The Contractor must have written credentialing and re-credentialing policies and procedures that do the following:
(a) Ensure quality of care
(b) Ensure that all providers rendering services to enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract
(c) Review the provider's record for fraud, waste, and abuse
(d) Verify that the provider is not debarred or suspended by any state or federal agency
(e) Require the provider to disclose criminal convictions related to federal healthcare programs
(f) Review the provider's employees, covered under **Section 1.022(L)(3)**, to ensure that these employees are not debarred or suspended by any state or federal agency
(g) Require the provider's employees, covered under **Section 1.022(L)(3)** to disclose criminal convictions related to federal healthcare programs

(2) Recredentialing

The Contractor must re-credential providers at least every three years. The Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. The Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards. If the plan declines to include providers in the plan's network, the plan must give the affected providers written notice of the reason for the decision.

W. Coordination of Care with Public and Community Providers and Organizations

(1) Local Organizations and Providers

The Contractor must work closely with local public and private community-based organizations and providers to address prevalent health care conditions and issues. Such agencies and organizations include local health departments, local DHS offices, family planning agencies, Substance Abuse Coordinating Agencies, community and migrant health centers, child and adolescent health centers and programs, and local or regional consortiums centered on various health conditions. Local coordination and collaboration with these entities will make a wider range of essential health care and support services available to the Contractor's enrollees.

To ensure that the services provided by these agencies are available to all Contractors, an individual Contractor must not require an exclusive contract as a condition of participation with the Contractor.

It is also beneficial for the Contractor to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, CAHCPs and FQHCs are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

(2) Maternal Infant Health Program Providers

The Contractor must establish and maintain agreements with the Maternal Infant Health Program (MIHP) providers in the Contractor's service area. Agreements between the Contractor and the MIHP providers must address the following issues:

(a) Medical coordination, include pharmacy and laboratory coordination
(b) Data and reporting requirements
(c) Quality assurance coordination
(d) Grievance and appeal resolution
(e) Dispute resolution

These agreements must be available for review upon request from DCH. The Contractor must present evidence of care coordination to DCH upon request.

The Contractor must refer all pregnant enrollees for MIHP screening and coordinate care with MIHP providers. The Contractor must present evidence of referrals and care coordination to DCH upon request.

X. Coordination of Care with Local Behavioral Health and Developmental Disability Providers

Some enrollees may also be eligible for services provided by Behavioral Health Services and Services for Persons with Developmental Disabilities managed care programs. The Contractor is not responsible for the direct delivery of specified behavioral health and developmental disability services as delineated in Medicaid Policy. However, the Contractor must establish and maintain agreements with local behavioral health and developmental disability agencies or organizations contracting with the State.

Agreements between the Contractor and the Local Behavioral Health and Development Disability managed care providers must address the following issues:

(1) Emergency services
(2) Pharmacy and laboratory service coordination
(3) Medical coordination
(4) Data and reporting requirements
(5) Quality assurance coordination
(6) Grievance and appeal resolution
(7) Dispute resolution

These agreements must be available for review upon request from DCH. The Contractor must coordinate care for enrollees who require integration of medical and behavioral health/substance abuse care. The Contractor must present evidence of care coordination to DCH upon request.

Y. Payment to Providers

The Contractor must make timely payments to all providers for covered services rendered to enrollees as required by MCL 400.111i and in compliance with established DCH performance standards (Appendix 4). Upon request from DCH, the Contractor must develop programs for improving access, quality, and performance with providers. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network providers dictated by the methodology jointly developed by the Contractor and DCH.

With the exception of newborns, the Contractor is not responsible for any payments owed to providers for services rendered prior to a beneficiary's enrollment with the Contractor's plan. Except for newborns, payment for services provided during a period of retroactive eligibility will be the responsibility of DCH.

The Contractor is responsible for annual IRS form 1099, Reporting of Provider Earnings, and must make all collected data available to DCH and, upon request, to CMS.

(1) Electronic Billing Capacity

The Contractor must meet the HIPAA and DCH guidelines and requirement for electronic billing capacity and may require its providers to meet the same standard as a condition for payment. HIPAA guidelines are found at www.michigan.gov/mdch.

Medicaid Policy and provider manuals specify the acceptable coding and procedures. Therefore, a provider must be able to bill a Contractor using the same format and coding instructions as that required for the Medicaid FFS programs. The Contractor may not require providers to complete additional fields on the electronic forms that are not specified under the Medicaid FFS policy and provider manuals. The Contractor may require additional documentation, such as medical records, to justify the level of care provided. In addition, health plans may require prior authorization for services for which the Medicaid FFS program does not require prior authorization.

DCH will update the web-site addresses of plans. This information will make it more convenient for providers (including out-of-network providers) to be aware of and contact respective health plans regarding documentation, prior authorization issues, and provider appeal processes. The Contractor is responsible for maintaining the completeness and accuracy of their web-sites regarding this information. The DCH web-site location is: www.michigan.gov/mdch.

(2) Payment Resolution Process

The Contractor must develop and maintain an effective provider appeal process to promptly resolve provider billing disputes. The Contractor will cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.

(3) Arbitration/Rapid Dispute Resolution

The Contractor must comply with the provisions of the Hospital Access Agreement. To resolve claim disputes with non-contracted hospital providers, the Contractor must follow the Rapid Dispute Resolution Process specified in the Medicaid Provider Manual. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution Process.
When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, the Contractor is required to participate in a binding arbitration process. Providers must exhaust the Contractor's internal provider appeal process before requesting arbitration.

DCH will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid.

The party found to be liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

(4) Post-Payment Review

The Contractor may utilize a post-payment review methodology to assure claims have been paid appropriately. The Contractor must complete post-payment reviews for individuals retroactively disenrolled by DCH within 90 days of the date that DCH notifies the Contractor of the retroactive of disenrollment. The plan must complete the recoupments from providers within 90 days of identifying the claims to be recouped. In no case, may the Contractor recoup money from providers for individuals retroactively disenrolled by DCH more than 180 days from the date that DCH notified the Contractor of the retroactive disenrollment.

(5) Total Payment

The Contractor or its providers may not require any co-payments, patient-pay amounts, or other cost-sharing arrangements unless authorized by DCH. The Contractor's providers must not bill enrollees for the difference between the provider's charge and the Contractor's payment for covered services. The Contractor's providers must not seek nor accept additional or supplemental payment from the enrollee, his/her family, or representative, in addition to the amount paid by the Contractor even when the enrollee signed an agreement to do so. These provisions also apply to out-of-network providers.

(6) Enrollee Liability for Payment

The enrollee must not be held liable for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR 438.116:

(a) The Contractor's debts, in case of insolvency
(b) Covered services under this Contract provided to the enrollee for which DCH did not pay the Contractor
(c) Covered services provided to the enrollee for which DCH or the Contractor does not pay the provider due to contractual, referral or other arrangement
(d) 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 Contractor provided the services directly

(7) Hospital Payments

The Contractor must pay out-of-network hospitals for all emergency and authorized covered services provided outside of the established network. Out-of-network hospital claims must be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid providers. Hospital payments must include payment for the DRG (as defined in the Medicaid Institutional Provider Chapter) outliers, as applicable, and capital costs at the per-discharge rate. Hospital payments must also include the applicable Graduate Medical Education (GME) payment in the amount and on the schedule dictated by DCH.

Upon request from DCH, the Contractor must develop programs for improving access, quality, and performance with both network and out-of-network hospitals. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network hospitals dictated by the methodology jointly developed by the Contractor and DCH.

Z. Quality Assessment and Performance Improvement Program

(1) Quality Assessment and Performance Improvement Program (QAPI)

The Contractor must have an ongoing QAPI program for the services furnished to its enrollees that meets the requirements of 42 CFR 438.240. The Contractor's Medical Director must be responsible for managing the QAPI program. The Contractor must maintain a Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including but not limited to the Quality Improvement Director and other key management staff, as well as health professionals providing care to enrollees.

The Contractor's QAPI program must be capable of identifying opportunities to improve the provision of health care services and the outcomes of such care for enrollees. The Contractor's QAPI program must incorporate and address findings of site reviews by DCH, external quality reviews, and statewide focus studies. In addition, the Contractor's QAPI program must develop or adopt performance improvement goals, objectives, and activities or interventions as required by DCH to improve service delivery or health outcomes for enrollees.

(a) The Contractor must have a written plan for the QAPI program that includes, at a minimum, the following:
  i. The Contractor's performance goals and objectives
  ii. Lines of authority and accountability
  iii. Data responsibilities
  iv. Performance improvement activities
  v. Evaluation tools

(b) The written plan must also describe how the Contractor will:
  i. Analyze the processes and outcomes of care using currently accepted standards from recognized medical authorities. The Contractor may include examples of focused review of individual cases, as appropriate
  ii. Determine underlying reasons for variations in the provision of care to enrollees
  iii. Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement
  iv. Use measures to analyze the delivery of services and quality of care, over and under utilization of services, disease management strategies, and outcomes of care. The Contractor must to collect and use data from multiple sources such as HEDIS®, medical records, encounter data, claims processing, grievances, utilization review, and member satisfaction instruments in this activity
  v. Compare QAPI program findings with past performance and with established program goals and available external standards
  vi. Measure the performance of providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers

vii. At least annually, provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor
viii. Develop and/or adopt, and periodically review, clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards
ix. Ensure that where applicable, utilization management, enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines
x. Evaluate access to care for enrollees according to the established standards and those developed by DCH and Contractor's QIC and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to enrollees with disabilities
xi. Perform a member satisfaction survey according to DCH specifications and distribute results to providers, enrollees, and DCH
xii. Implement improvement strategies related to program findings and evaluate progress at least annually
xiii. Maintain Contractor's written QAPI program that will be available at the annual on-site visit and to DCH upon request

(2) Annual Effectiveness Review
The Contractor must conduct an annual effectiveness review of its QAPI program. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for enrollees as a result of quality assessment and improvement activities and interventions carried out by the Contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the Contractor's QAPI program must be provided annually to network providers and to enrollees upon request. Information on the effectiveness of the Contractor's QAPI program must be provided to DCH annually during the on-site visit or upon request.

(3) Annual Performance Improvement Projects
The Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas. The Contractor must meet minimum performance objectives. The Contractor may be required to participate in statewide performance improvement projects that cover clinical and non-clinical areas.

DCH will collaborate with stakeholders and the Contractor to determine priority areas for statewide performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the population such as care of children, pregnant women, and persons with special health care needs, as defined by DCH. The Contractor must assess performance for the priority areas identified by the collaboration of DCH and other stakeholders.

(4) Performance Monitoring
DCH has established annual performance monitoring standards. The Contractor will incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QAPI program. DCH will use the results of performance assessments as part of the formula for automatic enrollment assignments. DCH will continually monitor the Contractor's performance on the performance monitoring standards and make changes as appropriate. The performance monitoring standards are attached to the Contract (Appendix 4).

(5) External Quality Review
DCH will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the Contractor. The Contractor will address the findings of the external review through its QAPI program. The Contractor must develop and implement performance improvement goals, objectives, and activities in response to the External Quality Review (EQR) findings as part of the Contractor's QAPI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the Contractor's QAPI program. DCH may also require separate submission of an improvement plan specific to the findings of the EQR.

(6) Consumer Survey
The Contractor must conduct an annual survey of their adult enrollee population using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument. The Contractor must directly contract with a National Committee for Quality Assurance (NCQA) certified CAHPS® vendor and submit the data according to the

specifications established by NCQA. Annually, the Contractor must provide NCQA summary and member level data to DCH. The Contractor must provide an electronic or hard copy of the final survey analysis report to DCH upon request.

AA. Utilization Management

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process

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

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review

(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

The Contractor's authorization policy must establish timeframes for standard and expedited authorization decisions. These timeframes may not exceed 14 calendar days from date of receipt for standard authorization decisions and 3 working days from date of receipt for expedited authorization decisions. These timeframes may be extended up to 14 additional calendar days if requested by the provider or enrollee and the Contractor justifies the need for additional information and explains how the extension is in the enrollee's interest. The enrollee must be notified of the plan's intent to extend the timeframe. The Contractor must ensure that compensation to the individuals or Subcontractor that conduct utilization management activities is not structured so as to provide incentives for the individual or Subcontractor to deny, limit, or discontinue medically necessary services to any enrollee.

BB. Third Party Resource Requirements

The Contractor will collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D. The Contractor will be responsible for identifying and collecting third party information and may retain third party collections. If third party resources are available, the Contractor is not required to pay the provider first and then recover money from the third party.

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a member's health care coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. The Contractor may retain all such collections. If TPL resources are available, the Contractor is not required to pay the provider first and then recover money from the third party; however, the Contractor may elect to "pay and chase." Contractors may research, identify and recover all sources of third party funds based on industry standards. The Contractor must follow Medicaid Policy regarding TPL. The Contractor must report third party collections in its encounter data submission and in aggregate as required by DCH.

DCH will provide the Contractor with a listing of known third party resources for its enrollees. The listing will be produced monthly and will contain information made available to DCH at the time of eligibility determination and/or re-determination. When denying a claim due to other insurance, the Contractor must provide the other insurance carrier ID, if known, to the billing provider.

When an enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any Contractor. The Contractor must make the enrollee whole by paying or otherwise covering all Medicare cost sharing amounts incurred by the enrollee such as coinsurance and deductibles.

CC. Marketing

(2) General Information

The Contractor may promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of an entire city, an entire county, or larger population segment in the Contractor's approved service area. Additionally, the Contractor may provide incentives, consistent with State law, to enrollees in the Contractor's plan that encourage healthy behavior and practices. All marketing and health promotion incentives must be approved by DCH prior to implementation. If the Contractor has previously received approval for a specific marketing or health promotion incentive and wishes to repeat the same marketing or health promotion incentive, the Contractor is not required to seek DCH approval. The Contractor must notify DCH of the intention to repeat the marketing or incentive, prior to implementation, and attest that the marketing or incentive is identical to the program previously approved by DCH.

Direct marketing to individual beneficiaries not enrolled with the Contractor is prohibited. For purposes of oral or written marketing material, as well as contact initiated by the beneficiary, the Contractor must adhere to the following guidelines:

(a) The Contractor may only provide factual information about the Contractor's services and contracted providers
(b) If the beneficiary requests information about services, the Contractor must inform the beneficiary that all MHPs are required, at a minimum, to provide the same services as the Medicaid FFS program
(c) The Contractor may not make comparisons with other MHPs
(d) The Contractor may not discuss enrollment, disenrollment, or Medicaid eligibility; the Contractor must refer all such inquiries to the State's enrollment broker

The Contractor may not provide inducements to beneficiaries or current enrollees through which compensation, reward, or supplementary benefits or services are offered to enroll or to remain enrolled with the Contractor.

(3) Examples of Allowed and Prohibited Marketing Locations and Practices

(a) Allowed Marketing Locations/Practices Directed at the General Population:

- Newspaper articles
- Newspaper advertisements
- Magazine advertisements
- Signs
- Billboards
- Pamphlets
- Brochures
- Radio advertisements
- Television advertisements
- Noncapitated plan sponsored events
- Public transportation (i.e. buses, taxicabs)

- Mailings to the general population
- Individual Contractor Health Fair for enrollee members as described in S**ection 1.022(CC)(3)**
- Malls or commercial retail establishments
- Community centers
- Churches

(b) Prohibited Marketing Locations/Practices that Target Individual Beneficiaries:

- Local DHS offices
- Provider offices, clinics, including but not limited to, WIC clinics, with the exception of window decals that have been approved by DCH
- Hospitals
- Check cashing establishments
- Door-to-door marketing
- Telemarketing
- Direct mail targeting individual Medicaid Beneficiaries not currently enrolled in the Contractor's plan

The prohibition of marketing in provider offices includes, but is not limited to, written materials distributed in the providers' office. The Contractor may not assist providers in developing marketing materials designed to induce beneficiaries to enroll or to remain enrolled with the Contractor or not disenroll from another Contractor. The Contractor may provide decals to participating providers which can include the health plan name and logo. These decals may be displayed in the provider office to show participation with the health plan. All decals must be approved by DCH prior to distribution to providers.

(4) Health Fairs

The Contractor may participate in health fairs that meet the following guidelines:

(a) Organized by an entity other than an MHP, such as, a local health department, a community agency, or a provider, for enrollees and the general public, or organized by the Contractor exclusively for the Contractor's enrollees
(b) Conducted in a public setting, such as a mall, a church, or a local health department. If the health fair is held in a provider office, all patients of the provider must be invited to attend. Health screenings may be provided as long as all participants in the health fair have the opportunity to be screened
(c) Beneficiary attendance is voluntary; no inducements other than incentives approved by DCH under this Contract may be used to encourage or require participation
(d) Advertisement of the health fair must be directed at the general population, be approved by DCH, and comply with all other requirements of **Section 1.022(CC)(1)**. A Contractor's name may be used in advertisements of the health fair only if DCH has approved the advertisement
(e) The purpose of the health fair must be to provide health education and/or promotional information or material, including information about managed care in general
(f) No direct information may be given regarding enrollment, disenrollment or Medicaid eligibility. If a beneficiary requests such information during the health fair, the Contractor must instruct the beneficiary to contact the State's enrollment broker
(g) No comparisons may be made between MHPs, other than by using material produced by a State Agency, including, but not limited to, the DCH Quality Check-Up

(5) Marketing Materials

All written and oral marketing materials and health promotion incentive materials must be approved by DCH prior to use. Upon receipt by DCH of a complete request for approval that proposes allowed marketing practices and locations, DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. The review clock will be tolled while the Contractor revises materials for re-submission.

If DCH has previously approved the Contractor's marketing material or an incentive program, the Contractor may request expedited approval. The Contractor must submit a copy of the material or incentive program and attest that none of the aspects of the marketing or incentive have changed. DCH will provide a decision within 10 calendar days or the Contractor's expedited request will be deemed approved.

Marketing materials must be available in languages appropriate to the beneficiaries being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the American with Disabilities Act.

DCH may impose monetary or restricted enrollment sanctions if the Contractor, any of its Subcontractors, or contracted providers engage in prohibited marketing practices or use marketing materials that have not been approved in writing by DCH.

Materials must be written at no higher than a 6.9 grade reading level as determined by any one of the following indices:

- Flesch – Kincaid
- Fry Readability Index
- PROSE The Readability Analyst (software developed by Educational Activities, Inc.)
- Gunning FOG Index
- McLaughlin SMOG Index
- Other computer generated readability indices accepted by DCH

DD. Contractor On-Site Reviews

Contractor on-site reviews by DCH will be an ongoing activity conducted during the Contract. The Contractor's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of health plan performance. These focus areas may include, but are not limited to the following:

- Administrative capabilities
- Governing body
- Subcontracts
- Provider network capacity and services
- Provider appeals
- Member services
- Primary care provider assignments and changes
- Enrollee grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care with the CMHSP and PIHP providers
- Claims processing
- Fraud and abuse

DCH will determine if the Contractor meets contractual requirements and assess health plan compliance. Deemed status is granted when a DCH approved accrediting agency has reviewed the criteria and determined that the plan meets the criteria. DCH reserves the right to conduct a comprehensive onsite review utilizing the site review tool.

EE. Contract Remedies and Sanctions

DCH will utilize a variety of means to assure compliance with Contract requirements. DCH will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented.

DCH may employ Contract remedies and/or sanctions to address any Contractor noncompliance with the Contract. Areas of noncompliance for which DCH may impose remedies and sanctions include, but are not limited to, noncompliance with Contract requirements on the following issues:

- Marketing practices
- Member services
- Provision of medically necessary, covered services
- Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services
- Provider networks
- Provider payments
- Financial requirements including but not limited to failure to comply with physician incentive plan requirements
- Enrollee satisfaction
- Performance standards included in Appendix 4 to the Contract
- Misrepresentation or false information provided to DCH, CMS, providers, enrollees, or potential enrollees

DCH may utilize intermediate sanctions (as described in 42.438.700) that may include suspension of enrollment and/or payment. Intermediate sanctions may also include the appointment of temporary management, as provided in 42 CFR 438.706. If a temporary management sanction is imposed, DCH will work concurrently with OFIR.

If intermediate sanctions or general remedies are not successful or DCH determines that immediate termination of the Contract is appropriate, as allowed by **Section 2.152**, the State may terminate the Contract with the Contractor. The Contractor must be afforded a hearing before termination of a Contract under this Section can occur. The State must notify enrollees of such a hearing and allow enrollees to disenroll, without cause, if they choose.

In addition to the sanctions described above, DCH will administer and enforce a monetary penalty of not more than $5,000.00 to a Contractor for each repeated failure on any of the findings of DCH site visit report. Collections of Contract sanctions will be through gross adjustments to the monthly payments described in **Section 1.062(A)** of this Contract and will be allocated to the fund established under **Section 1.062(B)** of the Contract for performance bonus.

FF. Medical Records

The Contractor must ensure that its providers maintain medical records of all medical services received by the enrollee. The medical record must include, at a minimum, a record of outpatient and emergency care, specialist referrals, ancillary care, diagnostic test findings including all laboratory and radiology, prescriptions for medications,

inpatient discharge summaries, histories and physicals, immunization records, and other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

(1) Medical Record Maintenance

The Contractor's medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment. Medical records must be signed and dated. All medical records must be retained for at least seven years.

The Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. The Contractor must have written plans for providing training and evaluating providers' compliance with the recognized medical records standards.

(2) Medical Record Confidentiality/Access

The Contractor must have written policies and procedures to maintain the confidentiality of all medical records. The Contractor must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information.

DCH and/or CMS shall be afforded prompt access to all enrollees' medical records. Neither CMS nor DCH are required to obtain written approval from an enrollee before requesting an enrollee's medical record. When an enrollee changes PCP, the former PCP must forward his or her medical records or copies of medical records to the new PCP within 10 working days from receipt of a written request.

1.030 Roles and Responsibilities

1.031 Contractor Staff, Roles, and Responsibilities

The Contractor must maintain administrative capability to deliver covered services to enrollees.

A. Organizational Structure

The Contractor's management approach and organizational structure must ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, grievance/appeal review, and management information systems.

The Contractor must be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. The Contractor must employ senior level managers with experience and expertise in health care management and must employ or contract with skilled clinicians for medical management activities.

The Contractor must provide a copy of the current organizational chart with reporting structures, names, and positions to DCH upon request. The Contractor must also provide a written narrative that documents the educational background, applicable licensure, relevant work experience, and current job description for the key personnel identified in the organizational chart.

The Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its provider network or in the conduct of the Contractor's affairs. The Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes managing employees, all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

The Contractor must provide to DCH, upon request, a notarized and signed disclosure statement fully disclosing the nature and extent of any contracts or arrangements between the Contractor or a provider or other person concerning any financial relationship with the Contractor and any one of the following:

- Providers – all contracted providers
- Provider employees – directors, officers, partners, managing employees, or persons with beneficial ownership of more than 5% of the entity's equity
- Contractor employees – director, officer, partner, managing employee, or persons with beneficial ownership of 5% or more of the entity's equity

The Contractor must notify DCH in writing of a substantial change in the facts set forth in the statement within 30 days of the date of the change. Information required to be disclosed in this Section shall also be available to the Department of Attorney General, Health Care Fraud Division.

B. Governing Body

Each Contractor must have a governing body. The governing body will ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body. The governing body must meet at least quarterly, and must keep a permanent record of all proceedings available to DCH and/or CMS upon request.

A minimum of 1/3 of the membership of the governing body must consist of adult enrollees who are not compensated officers, employees, stockholders who own 5% or more of the equity in the Contractor's plan, or other individuals responsible for the conduct of, or financially interested in, the Contractor's affairs. The Contractor must have written policies and procedures for governing body elections detailing, at a minimum, the following:

- How enrollee board members will be elected
- The length of the term for board members
- Filling of vacancies
- Notice to enrollees

The enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan.

C. Administrative Personnel

The Contractor must employ or contract with sufficient administrative staff to comply with all program standards. The Contractor must ensure that all staff has appropriate training, education, experience, licensure as appropriate, liability coverage, to fulfill the requirements of the positions. Resumes for personnel listed in subsections (1) through (11) below must be available upon request from DCH. Resumes must indicate the type and amount of experience each person has relative to the position. DCH will evaluate the sufficiency and competency of the Contractor's administrative personnel when considering Contractor's services area and enrollment expansion requests.

The State considers the following five positions to be key personnel. Therefore, the Contractor must inform DCH in writing within seven days of vacancies or staffing changes in the following key personnel:

- Chief Executive Officer (CEO)
- Compliance Officer
- Medical Director
- Chief Financial Officer (CFO)
- Management Information System Director

For the remainder of the required personnel described below, the Contractor must provide written notification to DCH of any vacancies or staffing changes within 30 days. For all vacancies, the Contractor must fill vacancies with qualified persons within six months of the vacancy unless an extension is granted by DCH.

The Contractor must provide the following positions (either through direct employment or contract):

(1) Executive Management

The Contractor must have a full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract including responsibility to oversee the budget and accounting systems implemented by the Contractor. The administrator must be responsible to the governing body for the daily conduct and operations of the Contractor's plan.

(2) Medical Director

The Medical Director must be a Michigan-licensed physician (MD or DO) and must be actively involved in all major clinical program components of the Contractor's plan including review of medical care provided, medical professional aspects of provider contracts, and other areas of responsibility as may be designated by the Contractor. The Medical Director must devote sufficient time to the Contractor's plan to ensure timely medical decisions, including after hours consultation as needed. The Medical Director must be responsible for managing the Contractor's Quality Assessment and Performance Improvement Program. The Medical Director must ensure compliance with State and local reporting laws on communicable diseases, child abuse, and neglect.

(3) Quality Improvement and Utilization Director

The Contractor must provide a full-time Quality Improvement and Utilization Director who is a Michigan licensed physician, Michigan licensed registered nurse, or another licensed clinician as approved by DCH based on the plan's ability to demonstrate that the clinician possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the Contract. The Contractor may provide a Quality Improvement Director and a Utilization Director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.

(4) Chief Financial Officer

The Contractor must provide a full-time CFO who is responsible for overseeing the budget and accounting systems implemented by the Contractor.

(5) Member Services Director

The Contractor must provide an individual responsible for coordinating communications with enrollees and other enrollee services such as acting as an enrollee advocate. There must be sufficient member service staff to enable enrollees to receive prompt resolution of their problems or inquiries.

(6) Provider Services Director

The Contractor must provide an individual responsible for coordinating communications between the Contractor and its Subcontractors and other providers. There must be sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.

(7) Grievance/Appeal Coordinator

The Contractor must provide staff to coordinate, manage, and adjudicate member and provider grievances.

(8) Management Information System Director

The Contractor's Management Information System (MIS) Director must be a full-time position that oversees and maintains the data management system to ensure the MIS is capable of valid data collection and processing, timely and accurate reporting, and correct claims payments.

(9) Compliance Officer

The Contractor must provide a full-time Compliance Officer to oversee the Contractor's compliance plan and to verify that fraud and abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

(10) Designated Liaisons

The Contractor must provide an MIS liaison and a general management (Medicaid) liaison. All communication between the Contractor and DCH must occur through the designated liaisons unless otherwise specified by DCH.

(11) Support/Administrative Staff

The Contractor must have adequate clerical and support staff to ensure that the Contractor's operation functions in accordance with all Contract requirements.

1.032 Responsibilities of the Michigan Department of Community Health

DCH will administer the CHCP, monitor Contractor performance, and conduct the following specific activities:

(1) Inform Contractor of beneficiaries' eligibility for the Medicaid program and determine which beneficiaries will be enrolled
(2) Determine if and when an enrollee will be disenrolled from the Contractor's plan or changed to another Medicaid managed care program
(3) Notify the Contractor of changes in enrollment
(4) Notify the Contractor of the enrollee's name, address, and telephone number if available. The Contractor will be notified of changes as they are known to DCH
(5) Issue Medicaid identification cards (mihealth card) to enrollees
(6) Provide the Contractor with information related to known third party resources and any subsequent changes and be responsible for reporting paternity related expenses to DHS
(7) Notify the Contractor of changes in covered services or conditions of providing covered services
(8) Maintain a Clinical Advisory Committee (CAC) to collaborate with Contractors on quality improvement
(9) Administer a Fair Hearing process consistent with federal requirements
(10) Collaborate with the Contractor on quality improvement activities, fraud and abuse issues, and other activities which impact the health care provided to enrollees
(11) Conduct a member satisfaction survey of child enrollees and compile and publish the results

(12) Review and approve all Contractor marketing and member information materials prior to distribution to enrollees
(13) Apply Contract remedies and sanctions, as necessary, to assure compliance with Contract requirements
(14) Monitor the operation of the Contractor to ensure access to quality care for enrollees
(15) Regularly monitor and evaluate the Contractor's compliance with Contract standards
(16) Provide data to Contractors at least 30 days before the effective date of FFS pricing or coding changes or Diagnosis Related Group (DRG) changes. DCH will provide this information to the Contractor in the most efficacious manner available so that the Contractor receives this information as soon as it is available to the DCH Project Manager. The manner of notification may include, but is not limited to, updates on the DCH web site, Excel files, and e-mail notification. Once the Contractor has been notified of FFS pricing, coding or DRG changes, in any manner, the Contractor is responsible for implementation of the change within 30 days
(17) Identify persons with special health care needs
(18) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. (State must provide this information to the Contractor at the time of enrollment)
(19) Protect against fraud and abuse involving Medicaid funds and enrollees in cooperation with appropriate State and federal authorities based upon the current DCH Fraud and Abuse plan that has been communicated to the Contractor
(20) Make all fraud and/or abuse referrals to the Department of Attorney General, Health Care Fraud Division
(21) Assess the quality and appropriateness of care and services furnished to all of Contractor's Medicaid enrollees and individuals with special health care needs utilizing information from required reports, on-site reviews, or other methods DCH determines appropriate
(22) Participate with Contractors in the design, data collection, and evaluation of system-wide programs to improve access, quality and performance

1.040 Project Plan

1.041 Project Plan Management – Deleted/Not Applicable

1.042 Reports

C. Data Reporting

(1) General

To measure the Contractor's accomplishments in the areas of access to care, utilization, medical outcomes, enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the Contractor must provide DCH with uniform data and information as specified by DCH. The Contractor must submit reports as specified in this Section. Any changes in the reporting requirements will be communicated to the Contractor at least 30 days before they are effective unless State or federal law requires otherwise.

In addition to the reports specified in this Section, DCH may request additional ad hoc information from the Contractor. The Contractor must comply with these requests for information within the timeframe specified in the request.

The Contractor must cooperate with DCH in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols. The Contractor must develop and implement corrective action plans to correct data validity problems as identified by DCH.

(2) Annual Report

The Contractor must submit an annual consolidated report described below using the instructions and format covered in Contract Appendix 3.

(a) Litigation Report: Contractors must submit an annual litigation report in a format established by DCH, providing detail for all civil litigation to which the Contractor, Subcontractor, or the Contractor's insurers or insurance agents are party

(b) Data Certification Report: The Contractor's CEO must submit a DCH Data Certification form to DCH that requires the Contractor to attest to the accuracy, completeness, and truthfulness of any and all data and documents submitted to the State as required by the Contract. When the health plan employs a new CEO, a new DCH Data Certification form must be submitted to DCH within 15 days of the employment date

(c) Quality Assurance and Performance Improvement Assessment: The Contractor must perform and document an annual assessment of their QAPI program. This assessment should include a description of any program completed and all ongoing quality improvement activities for the applicable year, an evaluation of the overall effectiveness of the program, and an annual work plan. DCH may also request other reports or improvement plans addressing specific Contract performance issues identified through site visit reviews, EQRs, focused studies, or other monitoring activities conducted by DCH

(d) EPSDT information: The Contractor must complete the EPSDT template provided by DCH and attach the following information:

iii. Copy of all educational documents used by the Contractor to inform children/guardians of availability of EPSDT services, age-appropriate immunizations and assistance from the Contractor on accessing EPSDT services

iv. List and provide a brief description of member incentives offered to increase member utilization of EPSDT services

v. List and provide a brief description of provider incentives offered to increase provider monitoring of / providing EPSDT services

vi. Copy of the Contractor's policy/policies that govern administration of the transportation benefit

(e) Health Plan Profile: The Contractor must provide all information requested on the Health Plan Profile form provided by DCH and attach all required documents

(f) Financial Reports: The Contractor must submit the Annual NAIC financial statement and all financial reports required by OFIR

(g) Physician Incentive Program (PIP) Reporting: The Contractor must submit the DCH PIP Attestation form and PIP Disclosure forms required by DCH

(h) Medicaid Provider Directory: The Contractor must provide one hard copy and one electronic copy of the Medicaid Provider Directory that is effective on the date the annual report is submitted to DCH

(i) Medicaid Certificate of Coverage: The Contractor must provide a copy of the Medicaid Certificate of Coverage that is approved and effective on the date the annual report is submitted to DCH

(j) Medicaid Member Handbook: The Contractor must provide a copy of the Medicaid Member Handbook that is approved and effective on the date the annual report is submitted to DCH.

(3) Additional Financial Reports

Contractors must meet all HMO financial reporting requirements and provide to DCH copies of the HMO financial reports. In addition to the annual financial reports submitted as part of the Annual Report, the Contractor must also submit the following financial reports in the format required by DCH and in the timeframe specified in Appendix 3:

- Quarterly NAIC financial reports
- Annual Management Discussion and Analysis
- Annual Audited Financial Statements

DCH may also require monthly financial statements from the Contractor.

(4) HEDIS® Submission

The Contractor must annually submit a Medicaid-product HEDIS® report according to the most current National Committee for Quality Assurance (NCQA) specifications and DCH timelines. The Contractor must contract with an NCQA certified HEDIS® vendor and undergo a full audit of their HEDIS® reporting process.

(5) Encounter Data Submission

The Contractor must submit encounter data containing detail for each patient encounter reflecting services provided by the Contractor. Encounter records will be submitted monthly via electronic media in a HIPAA compliant format as specified by DCH. The format can be found at www.michigan.gov/mdch.

Submitted encounter data will be subject to quality data edits prior to acceptance into DCH's data warehouse. The Contractor's data must pass all required data quality edits in order to be accepted into DCH's data warehouse. Any data that is not accepted into the DCH data warehouse will not be used in any analysis,

including but not limited to rate calculations, DRG calculations, and risk score calculations. DCH will not allow Contractors to submit incomplete encounter data for inclusion into the DCH data warehouse and subsequent calculations.

Stored encounter data will be subject to regular and ongoing quality checks as developed by DCH. DCH will give the Contractor a minimum of 60 days notice prior to the implementation of new quality data edits; however, DCH may implement informational edits without 60 days notice. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by DCH (see Appendix 4). The Contractor must participate in regular data quality assessments conducted as a component of ongoing encounter data on-site activity.

(6) Claims Reporting
The Contractor must provide to DCH monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by DCH.

(7) Semi-Annual Grievance and Appeal Report
The Contractor must track the number and type of grievances and appeals. This information must be summarized by the level at which the grievance or appeal was resolved and reported in the format designated by DCH. The Contractor must utilize the definition of grievance and appeal specified in this Contract for tracking and reporting grievance and appeals.

D. Release of Report Data
The Contractor must obtain DCH's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its enrollees other than as required by this Contract, statute or regulations. The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract. The Contractor will not use the State's data for any purpose other than providing the Services, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data. Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services and must disclose the information only to its employees on a strict need-to-know basis. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

1.050 Acceptance – Deleted/Not Applicable

1.051 Criteria – Deleted/Not Applicable

1.052 Final Acceptance – Deleted/Not Applicable

1.060 Proposal Pricing

1.061 Proposal Pricing – Deleted/Not Applicable

1.062 Price Terms

A. Payment Provisions
Payment under this Contract will consist of a fixed reimbursement plan with specific monthly payments. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. DCH will also pay a maternity case rate payment to the Contractor for enrollees who give birth while enrolled in the Contractor's plan. DCH will establish actuarially sound capitation rates developed in accordance with the federal requirements for actuarial soundness. The rates must be developed by an actuary who meets the qualifications of the American Academy of Actuaries utilizing a uniform and consistent

capitation rate development methodology that incorporates relevant information which may include: (a) the annual financial filings of all Contractors; (b) relevant Medicaid FFS data; (c) relevant Contractor encounter data.

The price per covered member will be risk adjusted (i.e., it will vary for different categories of enrollees). For enrollees in the Temporary Assistance for Needy Families (TANF) program categories, the risk adjustment will be based on age and gender. For enrollees in the Blind and Disabled program category, Michigan will utilize the Chronic Illness and Disability Payment System (CDPS) to adjust the capitation rates paid to the Contractor. Under CDPS, diagnosis coding as reported on claim and encounter transactions are used to compute a score for each individual. Individuals with inadequate eligibility history will be excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case mix value for each Contractor based on its enrolled population. The regional rate for the Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each Contractor. The aggregate impact will be budget or rate neutral. DCH will fully re-base the risk adjustment system annually. A limited adjustment to the case mix adjusted rates will occur in the intervening six month intervals based only on Contractor enrollment shifts.

DCH will annually review changes in implemented Medicaid Policy to determine the financial impact on the CHCP. Medicaid Policy changes reviewed under this Section include, but are not limited to, Medicaid policies implemented during the term of the Contract, changes in covered services, and modifications to Medicaid rates for covered services. If DCH determines that the policy changes significantly affect the overall cost to the CHCP, DCH will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

DCH will generate HIPAA-compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, DCH will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and DCH will report payments to Contractors on a HIPAA-compliant 820 file. A process will be in place to ensure timely payments and to identify enrollees that the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns). DCH may initiate a process to recoup capitation payments made to the Contractor for enrollees who were retroactively disenrolled or who are granted retroactive Medicare coverage.

The application of Contract remedies and performance bonus payments as described in **Sections 1.022(EE) and 1.062(B)** of this Contract will affect the lump-sum payment. Payments in any given fiscal year are contingent upon and subject to federal and State appropriations.

B. Contractor Performance Bonus

During each Contract year, DCH will withhold .0050 of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

DCH will establish a separate Targeted Performance Incentive Award. Funds allocated to this award will be distributed in equal proportions to each qualifying Contractor. DCH will establish the criteria used to distribute this award to Contractors.

C. Payment Option

Contracts are full-risk. However, the State reserves the right to offer a cost settlement option for inpatient services to Contractor's whose total plan membership is less than 10,000 members. The cost settlement option will be discontinued when the Contractor's total plan membership reaches 10,000.

1.063 Tax Excluded from Price

(a) Sales and Use Tax, Generally: The State is generally exempt from sales and use tax for direct purchases. The Contractor's prices must not include sales or use tax unless a specific exception applies.

(b) Use Tax, Specific Exception. MCL 205.93f sets out a specific exception to the State's general use tax exemption. This exception applies to contracts for purchase of medical services provided after April 1, 2009 from entities identified in MCL 400.106(2)(a), MCL 400.109f, or MCL 205.93f(2), involving certain Medicaid contract health plans and some specialty prepaid health plans. Purchases of services that fall under these provisions are subject to use tax.

(c) Federal Excise Tax: The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles are purchased under any resulting Contract for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free, or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax.

1.064 Holdback – Deleted/Not Applicable

***1.070 Additional Requirements* – Deleted/Not Applicable**

1.071 Additional Terms and Conditions specific to this Contract – Deleted/Not Applicable

Article 2 - Terms and Conditions

2.000 Contract Structure and Term

2.001 Contract Term
This Contract is for three years beginning 10/1/2009 through 9/30/2012. All outstanding Purchase Orders expire upon termination of the Contract, unless otherwise extended under the Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of the Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2.002 Options to Renew
This Contract may be renewed in writing by mutual agreement of the parties not less than 30 days before its expiration. The Contract may be renewed for up to three additional one year periods.

2.003 Legal Effect
Contractor must show acceptance of this Contract by signing two copies of the Contract and returning them to the Contract Administrator. The Contractor must not proceed with the performance of the work to be done under the Contract, including the purchase of necessary materials, until both parties have signed the Contract to show acceptance of its terms, and the Contractor receives a Contract release/purchase order that authorizes and defines specific performance requirements.

The State assumes no liability for costs incurred by Contractor or payment under this Contract, until Contractor is notified in writing that this Contract (or Change Order) has been approved by the State Administrative Board (if required), approved and signed by all the parties, and a Purchase Order against the Contract has been issued.

2.004 Attachments & Exhibits
All Attachments and Exhibits affixed to any Statement of Work, or appended to or referencing this Contract, are incorporated in their entirety and form part of this Contract.

2.005 Ordering – Deleted/Not Applicable

2.006 Order of Precedence
(a) The Contract, including any Statements of Work and Exhibits, to the extent not contrary to the Contract, each of which is incorporated for all purposes, constitutes the entire agreement between the parties with respect to the subject matter and supersedes all prior agreements, whether written or oral, with respect to the subject matter**.**

(b) In the event of any inconsistency between the terms of the Contract and a Statement of Work, the terms of the Statement of Work will take precedence (as to that Statement of Work only); provided, however, that a Statement of Work may not modify or amend the terms of the Contract, which may be modified or amended only by a formal Contract amendment.

2.007 Headings
Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of the Contract.

2.008 Form, Function & Utility – Deleted/Not Applicable

2.009 Reformation and Severability
Each provision of the Contract is severable from all other provisions of the Contract and, if one or more of the provisions of the Contract is declared invalid, the remaining provisions of the Contract remain in full force and effect.

2.010 Consents and Approvals
Except as expressly provided otherwise in the Contract, if either party requires the consent or approval of the other party for the taking of any action under the Contract, the consent or approval must be in writing and must not be unreasonably withheld or delayed.

2.011 No Waiver of Default
If a party fails to insist upon strict adherence to any term of the Contract then the party has not waived the right to later insist upon strict adherence to that term, or any other term, of the Contract.

2.012 Survival
Any provisions of the Contract that impose continuing obligations on the parties, including without limitation the parties' respective warranty, indemnity and confidentiality obligations, survive the expiration or termination of the Contract for any reason. Specific references to survival in the Contract are solely for identification purposes and not meant to limit or prevent the survival of any other Section.

2.020 Contract Administration

2.021 Issuing Office
This Contract is issued by the Department of Management and Budget, Purchasing Operations and Department of Community Health, Medical Services Administration (collectively, including all other relevant State of Michigan departments and agencies, the "State"). Purchasing Operations is the sole point of contact in the State with regard to all procurement and contractual matters relating to the Contract. Purchasing Operations **is the only State office authorized to change, modify, amend, alter or clarify the prices, specifications, terms and conditions of this Contract.** The Contractor Administrator within Purchasing Operations for this Contract is:

Kevin Dunn, Buyer Specialist
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909
DunnK3@michigan.gov
(517) 241-4225

2.022 Contract Compliance Inspector (CCI)
After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations, in consultation with Department of Community Health Contract Management Section will direct the person named below, or any other person so designated, to administer the contract to ensure the contract funds are adequate throughout the duration of the contract and that all contract changes are appropriately incorporated into the Contract by the Medical Services Administration. However, administering of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of the Contract as that authority is retained by DMB Purchasing Operations**. The Contract Compliance Inspector (CCI) for this Contract is:

Laura Dotson
Contract Management Section
Lewis Cass Building
320 South Walnut Street
Lansing, Michigan 48933
Dotsonl1@michigan.gov
(517) 241-4686

All communications regarding operation and implementation of this Contract are to be directed to the Project Manager named below.

2.023 Project Manager
After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations, in consultation with Department of Community Health, Medical Services Administration, will direct the person named below, or any other person so designated, to monitor and coordinate the activities for the Contract on a day-to-day basis during its term. However, monitoring of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of the Contract as that authority is retained by DMB Purchasing Operations**. The Project Manager for this Contract is:

Cheryl Bupp, Director
Managed Care Plan Division
Department of Community Health
400 S Pine Street
Lansing, MI 48933
buppc@michigan.gov

(517) 241-7933

2.024 Change Requests

During the course of ordinary business, it may become necessary for the State to discontinue certain business practices or create Additional Services/Deliverables. The State reserves the right, by giving Contractor written notice of a change request within a reasonable time, to request any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. In such an event, the Contractor must provide a detailed outline of all work to be done, including tasks necessary to accomplish the services/deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed proposal to implement the change.

The State may accept a Contractor's proposal for change, reject it, or reach another agreement with Contractor. Should the parties agree on carrying out a change, a written Contract Change Notice must be prepared and issued under this Contract, describing the change and its effects on the Services and any affected components of this Contract (a "Contract Change Notice"). No proposed Change may be performed until the proposed Change has been specified in a duly executed Contract Change Notice issued by the Department of Management and Budget, Purchasing Operations. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities.

If the State requests or directs the Contractor to perform any activities that Contractor believes constitute a change to the Statement of Work, the Contractor must notify the State that it believes the requested activities are a change before beginning to work on the requested activities. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities. If the Contractor commences performing work outside the scope of this Contract and then ceases performing that work, the Contractor must, at the request of the State, retract any out-of-scope work that would adversely affect the Contract.

2.025 Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

State:
Kevin Dunn, Buyer Specialist
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909

Contractor:
Beverly Allen
Omnicare Health Plan, Inc.
1333 Gratiot, Suite 400
Detroit, MI 48207

Either party may change its address where notices are to be sent by giving notice according to this Section.

2.026 Binding Commitments

Representatives of Contractor must have the authority to make binding commitments on Contractor's behalf within the bounds set forth in this Contract. Contractor may change the representatives upon written notice to the State.

2.027 Relationship of the Parties

The relationship between the State and Contractor is that of client and independent contractor. No agent, employee, or servant of Contractor or any of its Subcontractors will be deemed to be an employee, agent or servant of the State for any reason. Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and Subcontractors during the performance of the Contract.

2.028 Covenant of Good Faith
Each party must act reasonably and in good faith. Unless stated otherwise in the Contract, the parties will not unreasonably delay, condition or withhold the giving of any consent, decision or approval that is either requested or reasonably required of them in order for the other party to perform its responsibilities under the Contract.

2.029 Assignments
(a) Neither party may assign the Contract, or assign any of its duties or obligations under the Contract, to any other party (whether by operation of law or otherwise), without the prior written consent of the other party; provided, however, that the State may assign the Contract to any other State agency, department, division or department without the prior consent of Contractor and Contractor may assign the Contract to an affiliate so long as the affiliate is adequately capitalized and can provide adequate assurances that the affiliate can perform the Contract. The State may withhold consent from proposed assignments, subcontracts, or novations when the transfer of responsibility would operate to decrease the State's likelihood of receiving performance on the Contract or the State's ability to recover damages.

(b) Contractor may not, without the prior written approval of the State, assign its right to receive payments due under the Contract. If the State permits an assignment, the Contractor is not relieved of its responsibility to perform any of its contractual duties, and the requirement under the Contract that all payments must be made to one entity continues.

(c) If the Contractor intends to assign the Contract or any of the Contractor's rights or duties under the Contract, the Contractor must notify the State in writing at least 90 days before the assignment. The Contractor also must provide the State with adequate information about the assignee within a reasonable amount of time before the assignment for the State to determine whether to approve the assignment.

2.030 General Provisions

2.031 Media Releases
News releases (including promotional literature and commercial advertisements) pertaining to the Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with the Contract are to be released without prior written approval of the State and then only to persons designated.

2.032 Contract Distribution
Purchasing Operations retains the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Purchasing Operations.

2.033 Permits
Contractor must obtain and pay any associated costs for all required governmental permits, licenses and approvals for the delivery, installation and performance of the Services. The State must pay for all costs and expenses incurred in obtaining and maintaining any necessary easements or right of way.

2.034 Website Incorporation
The State is not bound by any content on the Contractor's website, even if the Contractor's documentation specifically referenced that content and attempts to incorporate it into any other communication, unless the State has actual knowledge of the content and has expressly agreed to be bound by it in a writing that has been manually signed by an authorized representative of the State.

2.035 Future Bidding Preclusion – Delete/Not Applicable

2.036 Freedom of Information
All information in any proposal submitted to the State by Contractor and this Contract is subject to the provisions of the Michigan Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, et seq. (the "FOIA").

2.037 Disaster Recovery
Contractor and the State recognize that the State provides essential services in times of natural or man-made disasters. Therefore, except as so mandated by Federal disaster response requirements, Contractor personnel dedicated to providing Services/Deliverables under this Contract will provide the State with priority service for repair and work around in the event of a natural or man-made disaster.

2.040 Financial Provisions

2.041 Fixed Prices for Services/Deliverables – Deleted/Not Applicable

2.042 Adjustments for Reductions in Scope of Services/Deliverables – Deleted/Not Applicable

2.043 Services/Deliverables Covered
For all Services/Deliverables to be provided by Contractor (and its Subcontractors, if any) under this Contract, the State must not be obligated to pay any amounts in addition to the PMPM payments and bonuses specified in this Contract.

2.044 Invoicing and Payment – In General – Deleted/Not Applicable

2.045 Pro-ration – Deleted/Not Applicable

2.046 Antitrust Assignment
The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this Contract.

2.047 Final Payment
The making of final payment by the State to Contractor does not constitute a waiver by either party of any rights or other claims as to the other party's continuing obligations under the Contract, nor will it constitute a waiver of any claims by one party against the other arising from unsettled claims or failure by a party to comply with this Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard. Contractor's acceptance of final payment by the State under this Contract must constitute a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still unsettled.

2.048 Electronic Payment Requirement
The Contractor is required to register with the State electronically at http://www.cpexpress.state.mi.us. As stated in Public Act 431 of 1984, all contracts that the State enters into for the purchase of goods and services must provide that payment will be made by electronic fund transfer (EFT).

2.050 Taxes

2.051 Employment Taxes
The Contractor must collect and pay all applicable federal, State, and local employment taxes, including the taxes.

2.052 Sales and Use Taxes
The Contractor is required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors lacking sufficient presence in Michigan to be required to register and pay taxes must do so voluntarily. This requirement extends to: (1) all members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member, and (2) all organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes. In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

2.060 Contract Management

2.061 Contractor Personnel Qualifications
All persons assigned by Contractor to the performance of Services under this Contract must be employees of Contractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved Subcontractor) and must be fully qualified to perform the work assigned to them. Contractor must include a similar provision in any subcontract entered into with a Subcontractor. For the purposes of this Contract, independent contractors engaged by Contractor solely in a staff augmentation role must be treated by the State as if they were employees of Contractor for this Contract only; however, the State understands that the relationship between Contractor and Subcontractor is an independent contractor relationship.

2.062 Contractor Key Personnel – Deleted/Not Applicable

2.063 Re-assignment of Personnel at the State's Request – Deleted/Not Applicable

2.064 Contractor Personnel Location – Deleted/Not Applicable

2.065 Contractor Identification – Deleted/Not Applicable

2.066 Cooperation with Third Parties
Contractor personnel and the personnel of any Subcontractors must cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, the Contractor will provide to the State's agents and other contractors reasonable access to Contractor's project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and will not interfere or jeopardize the safety or operation of the systems or facilities. The State acknowledges that Contractor's time schedule for the Contract is very specific and agrees not to unnecessarily or unreasonably interfere with, delay or otherwise impede Contractor's performance under this Contract with requests for access.

2.067 Contractor Return of State Equipment/Resources – Deleted/Not Applicable

2.068 Contract Management Responsibilities – Deleted/Not Applicable

2.070 Subcontracting by Contractor

Under this Contract, there are three classifications of Subcontractors:

Category I: Health Benefit Managers
Health Benefit Managers are entities that arrange for the provision of health services covered under this Contract, with the exclusion of transportation. Health Benefit Managers include, but are not limited to, Pharmacy Benefit Managers, Behavioral Health Benefit Managers, and Vision Benefit Managers. The Contractor must notify DCH of a new Health Benefit Manager 30 days prior to the effective date of the contract with the Health Benefit Manager. The State reserves the right to approve or reject the Contractor's proposed use of a Health Benefit Manager.

Category II: Administrative Subcontractors
In general, Administrative Subcontractors are entities that perform, for the Contractor, administrative functions required by this Contract such as claims payment, delegated credentialing, and card production and mailing services. These Administrative Subcontractors fall into three types described below. The Contractor must notify DCH of any new Administrative Subcontractors within 21 days of the effective date of the contract with the Administrative Subcontractor.

Type A Administrative Subcontractors perform administrative functions for the Contractor dealing with claims payment, third party liability, or another functions involving payment decisions

Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization management, or case-management

Type C Administrative Subcontractors perform miscellaneous administrative functions required by the Contract that do not involve payment or medical decisions. This type of administrative Subcontractor includes but is not limited to identification card production and mailing services

Category III: Transportation Subcontractor
Transportation Subcontractors are entities that arrange or arrange and provide transportation services covered under this Contract under a written subcontract with the Contractor. Transportation Subcontractors are divided into two types, as follows:

Type A Transportation Subcontractors perform Health Benefit Management services for the transportation benefit. These Subcontractors do not directly provide the transportation benefit, but rather, subcontract with other entities to provide the actual transportation. The Contractor must notify DCH of a new Type A Transportation Subcontractor 30 days prior to the effective date of the contract with the Health Benefit Manager. The State reserves the right to approve or reject the Contractor's proposed use of a Type A Transportation Subcontractor.

Type B Transportation Subcontractors are entities or agencies that arrange and provide the transportation services, such as social or religious agencies that provide transportation to covered services. The Contractor must notify DCH of any new Type B Transportation Subcontractors within 21 days of the effective date of the contract with the Subcontractor.

2.071 Contractor Full Responsibility

Contractor must have full responsibility for the successful performance and completion of all of the Services and Deliverables, whether or not the Contractor performs them. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted. The Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract including the insurance provisions specified in **Section 2.132**, as applicable. The Contractor is the sole point of contact for the State with regard to all contractual matters under this Contract, including payment of any and all charges for Services and Deliverables.

2.072 State Consent to Delegation

Contractor must not delegate any duties under this Contract to a Subcontractor except as specified above. The State has the right of prior written approval of Heath Benefit Managers and Type A Transportation Subcontractors and to require Contractor to replace any Heath Benefit Managers and Type A Transportation Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request will be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's will be based on good-faith reasons.

2.073 Subcontractor Bound to Contract

In any subcontracts entered into by Contractor for the performance of the Services, Contractor must require the Subcontractor, to the extent of the Services to be performed by the Subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The management of any Subcontractor will be the responsibility of Contractor, and Contractor will remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not subcontracted such performance. Contractor must make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State is not obligated to direct payments for the Services other than to Contractor. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under this Contract shall not relieve Contractor of any obligations or performance required under this Contract.

2.074 Flow Down

Except where specifically approved in writing by the State on a case-by-case basis, Contractor must flow down the obligations in **Sections 2.031, 2.060, 2.100, 2.110, 2.120, 2.130, 2.200** in all of its agreements with any Subcontractors as specified by type of subcontract.

2.075 Competitive Selection

The Contractor must select Subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the Contract.

2.080 State Responsibilities

2.081 Equipment – Deleted/Not Applicable

2.082 Facilities – Deleted/Not Applicable

2.090 Security

2.091 Background Checks

On a case-by-case basis, the State may investigate the Contractor's personnel before they may have access to State facilities and systems. The scope of the background check is at the discretion of the State and the results will be used to determine Contractor personnel eligibility for working within State facilities and systems. The investigations will include Michigan State Police Background checks (ICHAT) and may include the National Crime Information Center (NCIC) Finger Prints. Proposed Contractor personnel may be required to complete and submit an RI-8 Fingerprint Card for the NCIC Finger Print Check. Any request for background checks will be initiated by the State and will be reasonably related to the type of work requested.

All Contractor personnel will also be expected to comply with the State's security and acceptable use policies for State IT equipment and resources. See www.michigan.gov/dit. Furthermore, Contractor personnel will be expected to agree to the State's security and acceptable use policies before the Contractor personnel will be accepted as a resource to perform work for the State. It is expected the Contractor will present these documents to the prospective employee before the

Contractor presents the individual to the State as a proposed resource. Contractor staff will be expected to comply with all Physical Security procedures in place within the facilities where they are working.

2.092 Security Breach Notification

If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and State laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State in writing any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by the Contract within 10 days of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

2.093 PCI Data Security Requirements – Deleted/Not Applicable

2.100 Confidentiality

2.101 Confidentiality

Contractor and the State each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" of Contractor means all non-public proprietary information of Contractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary or with a similar designation. "Confidential Information" of the State means any information which is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, State and local laws and regulations) or which, in the case of tangible materials provided to Contractor by the State under its performance under this Contract, is marked as confidential, proprietary or with a similar designation by the State. "Confidential Information" excludes any information (including this Contract) that is publicly available under the Michigan FOIA.

2.102 Protection and Destruction of Confidential Information

The State and Contractor will each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Contractor nor the State will (i) make any use of the Confidential Information of the other except as contemplated by this Contract, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party will limit disclosure of the other party's Confidential Information to employees and Subcontractors who must have access to fulfill the purposes of this Contract. Disclosure to, and use by, a Subcontractor is permissible where (A) use of a Subcontractor is authorized under this Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Subcontractor's scope of responsibility, and (C) Contractor obligates the Subcontractor in a written Contract to maintain the State's Confidential Information in confidence.

At the State's request, any employee of Contractor and of any Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Contractor's and the Subcontractor's obligations under this Section and of the employee's obligation to Contractor or Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure.

Promptly upon termination or cancellation of the Contract for any reason, Contractor must certify to the State that Contractor has destroyed all State Confidential Information.

2.103 Exclusions

Notwithstanding the foregoing, the provisions of **Section 2.100** will not apply to any particular information which the State or Contractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Further, the provisions of **Section 2.100** will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

2.104 No Implied Rights

Nothing contained in this Section must be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

2.105 Respective Obligations
The parties' respective obligations under this Section must survive the termination or expiration of this Contract for any reason.

2.110 Records and Inspections

2.111 Inspection of Work Performed
The State's authorized representatives must at all reasonable times and with 10 days prior written request, have the right to enter Contractor's premises, or any other places, where the Services are being performed, and must have access, upon reasonable request, to interim drafts of Deliverables or work-in-progress. Upon 10 Days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Contractor must provide all reasonable facilities and assistance for the State's representatives.

2.112 Examination of Records
For seven years after the Contractor provides any work under this Contract (the "Audit Period"), the State may examine and copy any of Contractor's books, records, documents and papers pertinent to establishing Contractor's compliance with the Contract and with applicable laws and rules. The State must notify the Contractor 20 days before examining the Contractor's books and records. The State does not have the right to review any information deemed confidential by the Contractor to the extent access would require the Confidential Information to become publicly available. This provision also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor, or any Subcontractor of Contractor performing services in connection with the Contract.

2.113 Retention of Records
Contractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Contract and to the Services, equipment, and commodities provided under the Contract) pertaining to the Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State at any time during the Audit Period. If an audit, litigation, or other action involving Contractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later.

2.114 Audit Resolution
If necessary, the Contractor and the State will meet to review each audit report promptly after issuance. The Contractor will respond to each audit report in writing within 30 days from receipt of the report, unless a shorter response time is specified in the report. The Contractor and the State must develop, agree upon and monitor an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

2.115 Errors
(a) If the audit demonstrates any errors in the documents provided to the State, then the amount in error will be reflected as a credit or debit on a future pay cycle and in subsequent pay cycles until the amount is paid or refunded in full.

(b) In addition to other available remedies, the difference between the payment received and the correct payment amount is greater than 10%, then the Contractor must pay all of the reasonable costs of the audit.

2.120 Warranties

2.121 Warranties and Representations
The Contractor represents and warrants:

(a) It is capable in all respects of fulfilling and must fulfill all of its obligations under this Contract. The performance of all obligations under this Contract must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under this Contract.

(b) The Contract Appendices, Attachments and Exhibits identify the equipment and software and services necessary for the Deliverables to perform and Services to operate in compliance with the Contract's requirements and other standards of performance.

(c) It is the lawful owner or licensee of any Deliverable licensed or sold to the State by Contractor or developed by Contractor under this Contract, and Contractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Contractor to the State under neither this Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

(d) If, under this Contract, Contractor procures any equipment, software or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Contractor under Contractor's name), then in addition to Contractor's other responsibilities with respect to the items in this Contract, Contractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

(e) The Contract signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Contract, on behalf of Contractor.

(f) It is qualified and registered to transact business in all locations where required.

(g) Neither the Contractor nor any Affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of its duties and responsibilities to the State under this Contract or otherwise create an appearance of impropriety with respect to the award or performance of this Contract. Contractor must notify the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

(h) Neither Contractor nor any Affiliates, nor any employee of either has accepted or must accept anything of value based on an understanding that the actions of the Contractor or Affiliates or employee on behalf of the State would be influenced. Contractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

(i) Neither Contractor nor any Affiliates, nor any employee of either has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Contractor or the Affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of this Contract.

(j) Deleted/Not Applicable

(k) All financial statements, reports, and other information furnished by Contractor to the State in connection with the award of this Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Contractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information, there have been no material adverse change in the business, properties, financial condition, or results of operations of Contractor.

(l) All written information furnished to the State by or for the Contractor in connection with this Contract, including its bid, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

(m) It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Contractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Contractor failed to perform or otherwise breached an obligation of the Contract.

(n) If any of the certifications, representations, or disclosures made in the Contractor's original bid response change after Contract award, the Contractor is required to report those changes immediately to the Department of Management and Budget, Purchasing Operations.

2.122 Warranty of Merchantability – Deleted/Not Applicable

2.123 Warranty of Fitness for a Particular Purpose – Deleted/Not Applicable

2.124 Warranty of Title – Deleted/Not Applicable

2.125 Equipment Warranty – Deleted/Not Applicable

2.126 Equipment to be New – Deleted/Not Applicable

2.127 Prohibited Products – Deleted/Not Applicable

2.128 Consequences For Breach
In addition to any remedies available in law, if the Contractor breaches any of the warranties contained in this Section, the breach may be considered as a default in the performance of a material obligation of this Contract.

2.130 Insurance

2.131 Liability Insurance
The Contractor must provide proof of the minimum levels of insurance coverage as indicated below. The insurance must protect the State from claims which may arise out of or result from the Contractor's performance of services under the terms of this Contract, whether the services are performed by the Contractor, or by any Subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain under this Contract.

All insurance coverage's provided relative to this Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The insurance must be written for not less than any minimum coverage specified in this Contract or required by law, whichever is greater.

The insurers selected by Contractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required in this Contract must be issued by companies that have been approved to do business in the State. See www.michigan.gov/dleg.

Where specific limits are shown, they are the minimum acceptable limits. If Contractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits.

The Contractor is required to pay for and provide the type and amount of insurance checked ☑ below:

☑ 1. Commercial General Liability with the following minimum coverage:
$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:
$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☑ 6. Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☑ 7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

☐ 8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under this Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

2.132 Subcontractor Insurance Coverage

Except where the State has approved in writing a Contractor subcontract with other insurance provisions or as specified below, Contractor must require all of its Subcontractors under this Contract to purchase and maintain the insurance coverage as described in this Section for the Contractor in connection with the performance of work by those Subcontractors. Alternatively, Contractor may include any Subcontractors under Contractor's insurance on the coverage required in this Section. Subcontractors must fully comply with the insurance coverage required in this Section. Failure of Subcontractors to comply with insurance requirements does not limit Contractor's liability or responsibility.

Category I: Health Benefit Managers and Type A Transportation Subcontractors are required to pay for and provide the type and amount of insurance specified below:

☑ 1. Commercial General Liability with the following minimum coverage:
$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:
$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☑ 6. Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☑ 7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

☐ 8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under this Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

Category II, Type A – Administrative Subcontractors dealing with payment decisions are required to pay for and provide the type and amount of insurance listed below:

☐ 1. Commercial General Liability with the following minimum coverage:
$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☐ 6. Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☑ 7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

☐ 8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under this Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

Category II, Type B – Administrative Subcontractors dealing with medical decisions are required to pay for and provide the type and amount of insurance listed below:

☐ 1. Commercial General Liability with the following minimum coverage:

$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside

of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:
$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☐ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☐ 6. Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☑ 7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

☐ 8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under this Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

Type B Transportation Subcontractors must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract between the Contractor and Type B Transportation Subcontractor should require these Subcontractors to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage.

2.133 Certificates of Insurance and Other Requirements

Contractor must furnish to DMB-Purchasing Operations, certificates of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificate must be on the standard "accord" form or equivalent. **THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** All Certificates are to be prepared and submitted by the Insurance Provider. All Certificates must contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include the Contract or Purchase Order number affected. Before the Contract is signed, and not less than 20 days before the insurance expiration date every year thereafter, the Contractor must provide evidence that the State and its agents, officers and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

The Contractor must maintain all required insurance coverage throughout the term of the Contract and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of this Contract. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Contractor under this Contract to any indemnified party or other persons. Contractor is responsible for all deductibles with regard to the insurance. If the Contractor fails to pay any premium for required insurance as specified in this Contract, or if any insurer cancels or significantly reduces any required insurance as specified in this Contract without the State's written consent, then the State may, after the State has given the Contractor at least 30 days written notice, pay the premium or procure similar

insurance coverage from another company or companies. The State may deduct any part of the cost from any payment due the Contractor, or the Contractor must pay that cost upon demand by the State.

2.140 Indemnification

2.141 General Indemnification
To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from liability, including all claims and losses, and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties), accruing or resulting to any person, firm or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or tortious acts of the Contractor or any of its Subcontractors, or by anyone else for whose acts any of them may be liable.

2.142 Code Indemnification
To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from any claim, loss, or expense arising from Contractor's breach of the No Surreptitious Code Warranty.

2.143 Employee Indemnification
In any claims against the State of Michigan, its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its Subcontractors, the indemnification obligation under the Contract must not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its Subcontractors under worker's disability compensation acts, disability benefit acts or other employee benefit acts. This indemnification clause is intended to be comprehensive. Any overlap in provisions, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other provisions.

2.144 Patent/Copyright Infringement Indemnification
To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that the action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its Subcontractors, or the operation of the equipment, software, commodity or service, or the use or reproduction of any documentation provided with the equipment, software, commodity or service infringes any United States patent, copyright, trademark or trade secret of any person or entity, which is enforceable under the laws of the United States.

In addition, should the equipment, software, commodity, or service, or its operation, become or in the State's or Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor must at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if the option is not reasonably available to the Contractor, (ii) replace or modify to the State's satisfaction the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if the option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

Notwithstanding the foregoing, the Contractor has no obligation to indemnify or defend the State for, or to pay any costs, damages or attorneys' fees related to, any claim based upon (i) equipment developed based on written specifications of the State; (ii) use of the equipment in a configuration other than implemented or approved in writing by the Contractor, including, but not limited to, any modification of the equipment by the State; or (iii) the combination, operation, or use of the equipment with equipment or software not supplied by the Contractor under this Contract.

2.145 Continuation of Indemnification Obligations
The Contractor's duty to indemnify under this Section continues in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred before expiration or cancellation.

2.146 Indemnification Procedures
The procedures set forth below must apply to all indemnity obligations under this Contract.

(a) After the State receives notice of the action or proceeding involving a claim for which it will seek indemnification, the State must promptly notify Contractor of the claim in writing and take or assist Contractor in taking, as the case may be,

any reasonable action to avoid the imposition of a default judgment against Contractor. No failure to notify the Contractor relieves the Contractor of its indemnification obligations except to the extent that the Contractor can prove damages attributable to the failure. Within 10 days following receipt of written notice from the State relating to any claim, the Contractor must notify the State in writing whether Contractor agrees to assume control of the defense and settlement of that claim (a "Notice of Election"). After notifying Contractor of a claim and before the State receiving Contractor's Notice of Election, the State is entitled to defend against the claim, at the Contractor's expense, and the Contractor will be responsible for any reasonable costs incurred by the State in defending against the claim during that period.

(b) If Contractor delivers a Notice of Election relating to any claim: (i) the State is entitled to participate in the defense of the claim and to employ counsel at its own expense to assist in the handling of the claim and to monitor and advise the State about the status and progress of the defense; (ii) the Contractor must, at the request of the State, demonstrate to the reasonable satisfaction of the State, the Contractor's financial ability to carry out its defense and indemnity obligations under this Contract; (iii) the Contractor must periodically advise the State about the status and progress of the defense and must obtain the prior written approval of the State before entering into any settlement of the claim or ceasing to defend against the claim and (iv) to the extent that any principles of Michigan governmental or public law may be involved or challenged, the State has the right, at its own expense, to control the defense of that portion of the claim involving the principles of Michigan governmental or public law. But the State may retain control of the defense and settlement of a claim by notifying the Contractor in writing within 10 days after the State's receipt of Contractor's information requested by the State under clause (ii) of this paragraph if the State determines that the Contractor has failed to demonstrate to the reasonable satisfaction of the State the Contractor's financial ability to carry out its defense and indemnity obligations under this Section. Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. In the event the insurer's attorney represents the State under this Section, the insurer's attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

(c) If Contractor does not deliver a Notice of Election relating to any claim of which it is notified by the State as provided above, the State may defend the claim in the manner as it may deem appropriate, at the cost and expense of Contractor. If it is determined that the claim was one against which Contractor was required to indemnify the State, upon request of the State, Contractor must promptly reimburse the State for all the reasonable costs and expenses.

2.150 Termination/Cancellation

2.151 Notice and Right to Cure

If the Contractor breaches the Contract, and the State in its sole discretion determines that the breach is curable, then the State will provide the Contractor with written notice of the breach and a time period (not less than 30 days) to cure the Breach. The notice of breach and opportunity to cure is inapplicable for successive or repeated breaches or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage, or destruction of any real or tangible personal property.

2.152 Termination for Cause

(a) The State may terminate this Contract, for cause, by notifying the Contractor in writing, if the Contractor (i) breaches any of its material duties or obligations under this Contract or (ii) fails to cure a breach within the time period specified in the written notice of breach provided by the State

(b) If this Contract is terminated for cause, the Contractor must pay all costs incurred by the State in terminating this Contract, including but not limited to, State administrative costs, reasonable attorneys' fees and court costs, and any reasonable additional costs the State may incur to procure the Services/Deliverables required by this Contract from other sources. Re-procurement costs are not consequential, indirect or incidental damages, and cannot be excluded by any other terms otherwise included in this Contract, provided the costs are not in excess of 50% more than the prices for the Service/Deliverables provided under this Contract.

(c) Pursuant to 42 CFR 438.710, the Contractor must be afforded a hearing before termination of a Contract for cause can occur. The State must notify enrollees of such a hearing and allow enrollees to disenroll, without cause, if they choose.

(d) If the State chooses to partially terminate this Contract for cause, charges payable under this Contract will be equitably adjusted to reflect those Services/Deliverables that are terminated and the State must pay for all Services/Deliverables for which Final Acceptance has been granted provided up to the termination date. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

(e) If the State terminates this Contract for cause under this Section, and it is determined, for any reason, that Contractor was not in breach of contract under the provisions of this Section, that termination for cause must be deemed to have been a termination for convenience, effective as of the same date, and the rights and obligations of the parties must be limited to that otherwise provided in this Contract for a termination for convenience.

2.153 Termination for Convenience

The State may terminate this Contract for its convenience, in whole or part, if the State determines that a termination is in the State's best interest. Reasons for the termination must be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the Services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Services no longer practical or feasible, (c) unacceptable prices for Additional Services or New Work requested by the State, or (d) falsification or misrepresentation, by inclusion or non-inclusion, of information material to a response to any RFP issued by the State. The State may terminate this Contract for its convenience, in whole or in part, by giving Contractor written notice at least 30 days before the date of termination. If the State chooses to terminate this Contract in part, the charges payable under this Contract must be equitably adjusted to reflect those Services/Deliverables that are terminated. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

2.154 Termination for Non-Appropriation

(a) Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this Contract. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State must terminate this Contract and all affected Statements of Work, in whole or in part, at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to Contractor. The State must give Contractor at least 30 days advance written notice of termination for non-appropriation or unavailability (or the time as is available if the State receives notice of the final decision less than 30 days before the funding cutoff).

(b) If funding for the Contract is reduced by law, or funds to pay Contractor for the agreed-to level of the Services or production of Deliverables to be provided by Contractor are not appropriated or otherwise unavailable, the State may, upon 30 days written notice to Contractor, reduce the level of the Services or the change the production of Deliverables in the manner and for the periods of time as the State may elect. The charges payable under this Contract will be equitably adjusted to reflect any equipment, services or commodities not provided by reason of the reduction.

(c) If the State terminates this Contract, eliminates certain Deliverables, or reduces the level of Services to be provided by Contractor under this Section, the State must pay Contractor for all Work-in-Process performed through the effective date of the termination or reduction in level, as the case may be and as determined by the State, to the extent funds are available. This Section will not preclude Contractor from reducing or stopping Services/Deliverables or raising against the State in a court of competent jurisdiction any claim for a shortfall in payment for Services performed or Deliverables finally accepted before the effective date of termination.

2.155 Termination for Criminal Conviction

The State may terminate this Contract immediately and without further liability or penalty in the event Contractor, an officer of Contractor, or an owner of a 25% or greater share of Contractor is convicted of a criminal offense related to a State, public or private Contract or subcontract.

2.156 Termination for Approvals Rescinded

The State may terminate this Contract if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services under Michigan Constitution 1963, Article 11, § 5, and State of Michigan Civil Service Rule 7-1. In that case, the State will pay the Contractor for only the work completed to that point under the Contract. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in the written notice.

2.157 Rights and Obligations upon Termination

(a) If the State terminates this Contract for any reason, the Contractor must (a) stop all work as specified in the notice of termination, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Deliverables or other property derived or resulting from this Contract that may be in Contractor's possession, (c) return all materials and property provided directly or indirectly to Contractor by any entity, agent or employee of the State, (d) transfer title in, and deliver to, the State, unless otherwise directed, all Deliverables intended to be transferred to the State at the termination of the Contract and which are resulting from the Contract (which must be provided to the State on an "As-Is" basis except to the extent the amounts paid by the State in respect of the items included compensation to

Contractor for the provision of warranty services in respect of the materials), and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or termination settlement costs, to the maximum practical extent, including terminating or limiting as otherwise applicable those subcontracts and outstanding orders for material and supplies resulting from the terminated Contract.

(b) If the State terminates this Contract before its expiration for its own convenience, the State must pay Contractor for all charges due for Services provided before the date of termination and, if applicable, as a separate item of payment under this Contract, for Work-In-Process, on a percentage of completion basis at the level of completion determined by the State. All completed or partially completed Deliverables prepared by Contractor under this Contract, at the option of the State, becomes the State's property, and Contractor is entitled to receive equitable fair compensation for the Deliverables. Regardless of the basis for the termination, the State is not obligated to pay, or otherwise compensate, Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

(c) Upon a good faith termination, the State may assume, at its option, any subcontracts and agreements for services and deliverables provided under this Contract, and may further pursue completion of the Services/Deliverables under this Contract by replacement contract or otherwise as the State may in its sole judgment deem advantageous to the State.

2.158 Reservation of Rights
Any termination of this Contract or any Statement of Work issued under it by a party must be with full reservation of, and without prejudice to, any rights or remedies otherwise available to the party with respect to any claims arising before or as a result of the termination.

2.160 Termination by Contractor

2.161 Termination by Contractor
If the State breaches the Contract, and the Contractor in its sole discretion determines that the breach is curable, then the Contractor will provide the State with written notice of the breach and a time period (not less than 30 days) to cure the breach. The Notice of Breach and opportunity to cure is inapplicable for successive and repeated breaches.

The Contractor may terminate this Contract if the State (i) materially breaches its obligation to pay the Contractor undisputed amounts due and owing under this Contract, (ii) breaches its other obligations under this Contract to an extent that makes it impossible or commercially impractical for the Contractor to perform the Services, or (iii) does not cure the breach within the time period specified in a written notice of breach. But the Contractor must discharge its obligations under **Section 2.190** before it terminates the Contract.

2.170 Transition Responsibilities

2.171 Contractor Transition Responsibilities
If the State terminates this Contract, for convenience or cause, or if the Contract is otherwise dissolved, voided, rescinded, nullified, expired or rendered unenforceable, the Contractor agrees to comply with direction provided by the State to assist in the orderly transition of equipment, services, software, leases, etc. to the State or a third party designated by the State. If this Contract expires or terminates, the Contractor agrees to make all reasonable efforts to effect an orderly transition of services within a reasonable period of time that in no event will exceed 2 years These efforts must include, but are not limited to, those listed in **Sections 2.171, 2.172, 2.173, 2.174, and 2.175.**

2.172 Contractor Personnel Transition
The Contractor must work with the State, or a specified third party, to develop a transition plan setting forth the specific tasks and schedule to be accomplished by the parties to effect an orderly transition. The Contractor must allow as many personnel as practicable to remain on the job to help the State, or a specified third party, maintain the continuity and consistency of the services required by this Contract. In addition, during or following the transition period, in the event the State requires the Services of the Contractor's Subcontractors or vendors, as necessary to meet its needs, Contractor agrees to reasonably, and with good-faith, work with the State to use the Services of Contractor's Subcontractors or vendors. Contractor will notify all of Contractor's Subcontractors of procedures to be followed during transition.

2.173 Contractor Information Transition
The Contractor agrees to provide reasonable detailed specifications for all Services/Deliverables needed by the State, or specified third party, to properly provide the Services/Deliverables required under this Contract. The Contractor will provide the State with asset management data generated from the inception of this Contract through the date on which this Contractor is terminated in a comma-delineated format unless otherwise requested by the State. The Contractor will deliver to the State any remaining owed reports and documentation still in Contractor's possession subject to appropriate payment by the State.

2.174 Contractor Software Transition
The Contractor must reasonably assist the State in the acquisition of any Contractor software required to perform the Services/use the Deliverables under this Contract. This must include any documentation being used by the Contractor to perform the Services under this Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level. Upon notification by the State, Contractor may be required to freeze all non-critical changes to Deliverables/Services.

2.175 Transition Payments
If the transition results from a termination for any reason, reimbursement must be governed by the termination provisions of this Contract. If the transition results from expiration, the Contractor will be reimbursed for all reasonable transition costs (i.e. costs incurred within the agreed period after contract expiration that result from transition operations) at the rates agreed upon by the State. The Contractor will prepare an accurate accounting from which the State and Contractor may reconcile all outstanding accounts.

2.176 State Transition Responsibilities
In the event that this Contract is terminated, dissolved, voided, rescinded, nullified, or otherwise rendered unenforceable, the State agrees to perform the following obligations, and any others upon which the State and the Contractor agree:
(a) Reconciling all accounts between the State and the Contractor
(b) Completing any pending post-project reviews

2.180 Stop Work

2.181 Stop Work Orders
The State may, at any time, by written Stop Work Order to Contractor, require that Contractor stop all, or any part, of the work called for by the Contract for a period of up to 90 calendar days after the Stop Work Order is delivered to Contractor, and for any further period to which the parties may agree. The Stop Work Order will be identified as a Stop Work Order and must indicate that it is issued under this **Section 2.180**. Upon receipt of the Stop Work Order, Contractor must immediately comply with its terms and take all reasonable steps to minimize incurring costs allocable to the work covered by the Stop Work Order during the period of work stoppage. Within the period of the Stop Work Order, the State must either: (a) cancel the Stop Work Order; or (b) terminate the work covered by the Stop Work Order as provided in **Section 2.150**.

2.182 Cancellation or Expiration of Stop Work Order
The Contractor must resume work if the State cancels a Stop Work Order or if it expires. The parties will agree upon an equitable adjustment in the delivery schedule, the Contract price, or both, and the Contract must be modified, in writing, accordingly, if: (a) the Stop Work Order results in an increase in the time required for, or in Contractor's costs properly allocable to, the performance of any part of the Contract; and (b) Contractor asserts its right to an equitable adjustment within 30 calendar days after the end of the period of work stoppage; provided that, if the State decides the facts justify the action, the State may receive and act upon a Contractor proposal submitted at any time before final payment under the Contract. Any adjustment will conform to the requirements of **Section 2.024**.

2.183 Allowance of Contractor Costs
If the Stop Work Order is not canceled and the work covered by the Stop Work Order is terminated for reasons other than material breach, the termination must be deemed to be a termination for convenience under **Section 2.150**, and the State will pay reasonable costs resulting from the Stop Work Order in arriving at the termination settlement. For the avoidance of doubt, the State is not liable to Contractor for loss of profits because of a Stop Work Order issued under this **Section 2.180.**

2.190 Dispute Resolution

2.191 In General

Any claim, counterclaim, or dispute between the State and Contractor arising out of or relating to the Contract or any Statement of Work must be resolved as follows. For all Contractor claims seeking an increase in the amounts payable to Contractor under the Contract, or the time for Contractor's performance, Contractor must submit a letter, together with all data supporting the claims, executed by Contractor's Contract Administrator or the Contract Administrator's designee certifying that (a) the claim is made in good faith;

(b) the amount claimed accurately reflects the adjustments in the amounts payable to Contractor or the time for Contractor's performance for which Contractor believes the State is liable and covers all costs of every type to which Contractor is entitled from the occurrence of the claimed event; and (c) the claim and the supporting data are current and complete to Contractor's best knowledge and belief.

2.192 Informal Dispute Resolution

(a) All disputes between the parties must be resolved under the Contract Management procedures in this Contract. If the parties are unable to resolve any disputes after compliance with the processes, the parties must meet with the Director of Purchasing Operations, DMB, or designee, for the purpose of attempting to resolve the dispute without the need for formal legal proceedings, as follows:

(i) The representatives of Contractor and the State must meet as often as the parties reasonably deem necessary to gather and furnish to each other all information with respect to the matter in issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives must discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding

(ii) During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to the Contract will be honored in order that each of the parties may be fully advised of the other's position

(iii) The specific format for the discussions will be left to the discretion of the designated State and Contractor representatives, but may include the preparation of agreed upon statements of fact or written statements of position

(iv) Following the completion of this process within 60 calendar days, the Director of Purchasing Operations, DMB, or designee, must issue a written opinion regarding the issues in dispute within 30 calendar days. The opinion regarding the dispute must be considered the State's final action and the exhaustion of administrative remedies.

(b) This Section will not be construed to prevent either party from instituting, and a party is authorized to institute, formal proceedings earlier to avoid the expiration of any applicable limitations period, to preserve a superior position with respect to other creditors, or request for injunctive relief under **Section 2.193**.

(c) The State will not mediate disputes between the Contractor and any other entity, except State agencies, concerning responsibility for performance of work under the Contract.

2.193 Injunctive Relief

The only circumstance in which disputes between the State and Contractor will not be subject to the provisions of **Section 2.192** is where a party makes a good faith determination that a breach of the terms of the Contract by the other party is the that the damages to the party resulting from the breach will be so immediate, so large or severe and so incapable of adequate redress after the fact that a temporary restraining order or other immediate injunctive relief is the only adequate remedy.

2.194 Continued Performance

Each party agrees to continue performing its obligations under the Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate the Contract as provided in **Section 2.150**, as the case may be.

2.200 Federal and State Contract Requirements

2.201 Nondiscrimination
In the performance of the Contract, Contractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability. Contractor further agrees that every subcontract entered into for the performance of this Contract or any Purchase Order resulting from this Contract will contain a provision requiring non-discrimination in employment, as specified here, binding upon each Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., and any breach of this provision may be regarded as a material breach of the Contract.

2.202 Unfair Labor Practices
Under 1980 PA 278, MCL 423.321, et seq., the State must not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. A Contractor of the State, in relation to the Contract, must not enter into a contract with a Subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any Contract if, after award of the Contract, the name of Contractor as an employer or the name of the Subcontractor, manufacturer or supplier of Contractor appears in the register.

2.203 Workplace Safety and Discriminatory Harassment
In performing Services for the State, the Contractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see www.mi.gov/mdcs/0,1607,7-147-6877---,00.html.

2.210 Governing Law

2.211 Governing Law
The Contract must in all respects be governed by, and construed according to, the substantive laws of the State of Michigan without regard to any Michigan choice of law rules that would apply the substantive law of any other jurisdiction to the extent not inconsistent with, or pre-empted by federal law.

2.212 Compliance with Laws
Contractor must comply with all applicable state, federal and local laws and ordinances in providing the Services/Deliverables.

2.213 Jurisdiction
Any dispute arising from the Contract must be resolved in the State of Michigan. With respect to any claim between the parties, Contractor consents to venue in Ingham County, Michigan, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non conveniens or otherwise. Contractor agrees to appoint agents in the State of Michigan to receive service of process.

2.220 Limitation of Liability

2.221 Limitation of Liability
Neither the Contractor nor the State is liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability does not apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of this Contract calling for liquidated damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on this Contract.

2.230 Disclosure Responsibilities

2.231 Disclosure of Litigation

(a) Disclosure. Contractor must disclose any material criminal litigation, investigations or proceedings involving the Contractor (and each Subcontractor) or any of its officers or directors or any litigation, investigations or proceedings under the Sarbanes-Oxley Act. In addition, each Contractor (and each Subcontractor) must notify the State of any material civil litigation, arbitration or proceeding which arises during the term of the Contract and extensions, to which Contractor (or, to the extent Contractor is aware, any Subcontractor) is a party, and which involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Contractor or any Subcontractor; or (ii) a claim or written allegation of fraud against Contractor or, to the extent Contractor is aware, any Subcontractor by a governmental or public entity arising out of their business dealings with governmental or public entities. The Contractor must disclose in writing to the Contract Administrator any litigation, investigation, arbitration or other proceeding (collectively, "Proceeding") within 30 days of its occurrence. Details of settlements which are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Contractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section.

(b) Assurances. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of this Contract would cause a reasonable party to be concerned about:

(i) The ability of Contractor (or a Subcontractor) to continue to perform this Contract according to its terms and conditions, or

(ii) whether Contractor (or a Subcontractor) in performing Services for the State is engaged in conduct which is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of this Contract or a violation of Michigan law, regulations or public policy, then the Contractor must provide the State all reasonable assurances requested by the State to demonstrate that:

(a) Contractor and its Subcontractors will be able to continue to perform this Contract and any Statements of Work according to its terms and conditions, and

(b) Contractor and its Subcontractors have not and will not engage in conduct in performing the Services which is similar in nature to the conduct alleged in the Proceeding

(c) Contractor must make the following notifications in writing:

(1) Within 30 days of Contractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records, Contractor must notify DMB Purchasing Operations.

(2) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers

(3) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to company affiliations occur

2.232 Call Center Disclosure – Deleted/Not Applicable

2.233 Bankruptcy

The State may, without prejudice to any other right or remedy, terminate this Contract, in whole or in part, and, at its option, may take possession of the "Work in Process" and finish the Works in Process by whatever appropriate method the State may deem expedient if:

(a) The Contractor files for protection under the bankruptcy laws

(b) An involuntary petition for bankruptcy is filed against the Contractor and not removed within 30 days

(c) The Contractor becomes insolvent or if a receiver is appointed due to the Contractor's insolvency

(d) The Contractor makes a general assignment for the benefit of creditors

(e) The Contractor or its affiliates are unable to provide reasonable assurances that the Contractor or its affiliates can deliver the services under this Contract

Contractor will fix appropriate notices or labels on the Work in Process to indicate ownership by the State. To the extent reasonably possible, materials and Work in Process must be stored separately from other stock and marked conspicuously with labels indicating ownership by the State.

2.240 Performance – Deleted/Not Applicable

2.241 Time of Performance – Deleted/Not Applicable

2.242 Service Level Agreements (SLAs) – Deleted/Not Applicable

2.243 Liquidated Damages – Deleted/Not Applicable

2.244 Excusable Failure – Deleted/Not Applicable

2.250 Approval of Deliverables – Deleted/Not Applicable

2.251 Delivery Responsibilities – Deleted/Not Applicable

2.252 Delivery of Deliverables – Deleted/Not Applicable

2.253 Testing – Deleted/Not Applicable

2.254 Approval of Deliverables, In General – Deleted/Not Applicable

2.255 Process For Approval of Written Deliverables – Deleted/Not Applicable

2.256 Process for Approval of Services – Deleted/Not Applicable

2.257 Process for Approval of Physical Deliverables – Deleted/Not Applicable

2.258 Final Acceptance – Deleted/Not Applicable

2.260 Ownership – Deleted/Not Applicable

2.270 State Standards

2.271 Existing Technology Standards
The Contractor will adhere to all existing standards as described within the comprehensive listing of the State's existing technology standards at www.michigan.gov/dit.

2.272 Acceptable Use Policy
To the extent that Contractor has access to the State computer system, Contractor must comply with the State's Acceptable Use Policy; see www.michigan.gov/ditservice. All Contractor employees must be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State system. The State reserves the right to terminate Contractor's access to the State system if a violation occurs.

2.273 Systems Changes
Contractor is not responsible for and not authorized to make changes to any State systems without written authorization from the Project Manager. Any changes Contractor makes to State systems with the State's approval must be done according to applicable State procedures, including security, access and configuration management procedures.

2.280 Extended Purchasing – Deleted/Not Applicable

2.281 MIDEAL – Deleted/Not Applicable

2.282 State Employee Purchases – Deleted/Not Applicable

2.290 Environmental Provision

2.291 Environmental Provision
Energy Efficiency Purchasing Policy – The State seeks wherever possible to purchase energy efficient products. This includes giving preference to U.S. Environmental Protection Agency (EPA) certified "Energy Star" products for any category of products for which EPA has established Energy Star certification. For other purchases, the State may include energy efficiency as one of the priority factors to consider when choosing among comparable products.

Environmental Purchasing Policy – The State of Michigan is committed to encouraging the use of products and services that impact the environment less than competing products. The State is accomplishing this by including environmental

considerations in purchasing decisions, while remaining fiscally responsible, to promote practices that improve worker health, conserve natural resources, and prevent pollution. Environmental components that are to be considered include: recycled content and recyclability; energy efficiency; and the presence of undesirable materials in the products, especially those toxic chemicals which are persistent and bioaccumulative. The Contractor should be able to supply products containing recycled and environmentally preferable materials that meet performance requirements and is encouraged to offer such products throughout the duration of this Contract. Information on any relevant third party certification (such as Green Seal, Energy Star, etc.) should also be provided.

Hazardous Materials – For the purposes of this Section, "Hazardous Materials" is a generic term used to describe asbestos, ACBMs, PCBs, petroleum products, construction materials including paint thinners, solvents, gasoline, oil, and any other material the manufacture, use, treatment, storage, transportation or disposal of which is regulated by the federal, state or local laws governing the protection of the public health, natural resources or the environment. This includes, but is not limited to, materials the as batteries and circuit packs, and other materials that are regulated as (1) "Hazardous Materials" under the Hazardous Materials Transportation Act, (2) "chemical hazards" under the Occupational Safety and Health Administration standards, (3) "chemical substances or mixtures" under the Toxic Substances Control Act, (4) "pesticides" under the Federal Insecticide Fungicide and Rodenticide Act, and (5) "hazardous wastes" as defined or listed under the Resource Conservation and Recovery Act.

(a) The Contractor must use, handle, store, dispose of, process, transport and transfer any material considered a Hazardous Material according to all federal, State and local laws. The State must provide a safe and suitable environment for performance of Contractor's Work. Before the commencement of Work, the State must advise the Contractor of the presence at the work site of any Hazardous Material to the extent that the State is aware of the Hazardous Material. If the Contractor encounters material reasonably believed to be a Hazardous Material and which may present a substantial danger, the Contractor must immediately stop all affected Work, notify the State in writing about the conditions encountered, and take appropriate health and safety precautions.

(b) Upon receipt of a written notice, the State will investigate the conditions. If (a) the material is a Hazardous Material that may present a substantial danger, and (b) the Hazardous Material was not brought to the site by the Contractor, or does not result in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Materials, the State must order a suspension of Work in writing. The State must proceed to have the Hazardous Material removed or rendered harmless. In the alternative, the State must terminate the affected Work for the State's convenience.

(c) Once the Hazardous Material has been removed or rendered harmless by the State, the Contractor must resume Work as directed in writing by the State. Any determination by the DCH or the Michigan Department of Environmental Quality that the Hazardous Material has either been removed or rendered harmless is binding upon the State and Contractor for the purposes of resuming the Work.

(d) If the Hazardous Material was brought to the site by the Contractor, or results in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Material, or from any other act or omission within the control of the Contractor, the Contractor must bear its proportionate share of the delay and costs involved in cleaning up the site and removing and rendering harmless the Hazardous Material according to Applicable Laws to the condition approved by applicable regulatory agency(ies).
Michigan has a Consumer Products Rule pertaining to labeling of certain products containing volatile organic compounds. For specific details visit www.michigan.gov/deq/0,1607,7-135-3310_4108-173523--,00.html

Refrigeration and Air Conditioning – The Contractor must comply with the applicable requirements of Sections 608 and 609 of the Clean Air Act (42 U.S.C. 7671g and 7671h) as each or both apply to this Contract.

Waste Reduction Program – Contractor must establish a program to promote cost-effective waste reduction in all operations and facilities covered by this Contract. The Contractor's programs must comply with applicable Federal, State, and local requirements, specifically including Section 6002 of the Resource Conservation and Recovery Act (42 U.S.C. 6962, et seq.).

Appendix 1
Rural Area Exception Counties

The following are counties qualified for the Rural Area Exception. Implementation of the Rural Area Exception in any county will be determined by DCH with approval from CMS.

Alcona
Alger
Alpena
Arenac
Baraga
Bay
Benzie
Chippewa
Clare
Crawford
Delta
Dickinson
Gladwin
Gogebic
Gratiot
Houghton
Huron
Iosco
Iron
Isabella
Keweenaw
Luce
Mackinac
Manistee
Marquette
Menominee
Midland
Missaukee
Montmorency
Ogemaw
Ontonagon
Oscoda
Otsego
Presque Isle
Roscommon
Saginaw
Sanilac
Schoolcraft
Tuscola
Wexford

Appendix 2
DCH Financial Monitoring Standards

Reporting Period	Monitoring Indicator	Threshold	DCH Action	Health Plan Action
Quarterly Financial	Working Capital	Below minimum	DCH written notification	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance
Quarterly Financial	Net Worth	Negative Net Worth	DCH written notification Freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	150-200% RBC	DCH written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	100-149% RBC	DCH written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 days of DCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

Appendix 3
2010 Reporting Requirements for Medicaid Health Plans

Reports must be submitted to the contract manager; **exceptions** are the encounter data which is submitted electronically via the DEG and the monthly claims report which is submitted via E-mail to wolfs@michigan.gov. Reports must submitted to the Contract Manager (not other Departments or Sections) to be logged as received.

Report	Due Date	Period Covered	Instructions/Format
ANNUAL			
Consolidated Annual Report	3/1/10	1/1/10 - 12/31/10	Contract Section 1.042
Management Discussion and Analysis for Annual Financial	4/1/10	1/1/10 - 12/31/10	Contract Section 1.042
Audited Financial Statements	6/1/10	1/1/10 - 12/31/10	NAIC, OFIR
HEDIS® IDSS	6/30/10	1/1/10 - 12/31/10	NCQA- 1 hard copy and 1 electronic copy
HEDIS® Compliance Audit Report	7/30/10	1/1/10 - 12/31/10	NCQA
QIP Annual Evaluation and Work Plan	6/30/10	Current Approved Evaluation and Work Plan	Electronic Format; Contract 1.022(Z)
SEMI-ANNUAL			
Complaint and Grievance	1/30/10 7/30/10	7/1/10 - 12/31/10 1/1/10 - 6/30/10	MSA 131
QUARTERLY			
Financial	5/15/10 8/15/10 11/15/10	1/1/10 - 3/31/10 4/1/10 - 6/30/10 7/1/10 - 9/30/10	NAIC and OFIR
Third Party Collection	5/15/10 8/15/10 11/15/10	1/1/10 - 3/31/10 4/1/10 - 6/30/10 7/1/10 - 9/30/10	Report on separate sheet and send with NAIC
MONTHLY			
Claims Processing	30 days after end of month *NOT last day of month*	•Data covers previous month •i.e., data for 2/10 due by 3/30/10	MSA 2009(E) Revised 9/03
Encounter Data	The 15th of each month	•Minimum of Monthly •Data covers previous month •i.e., data for 1/10 due by 2/15/10	837 Format NCPDP Format

1. Annual Report Components
   - Health Plan Profile (MSA 126) *NOTE:* ***Follow instructions carefully and include all required attachments.***
   - Financial (NAIC, all reports required by OFIR, and Statement of Actuarial Opinion) are due with the annual report on 3/1/10. *NOTE: The Management Discussion and Analysis is due 4/1/10 and the Audited Financial Statements are due 6/1/10.*
   - Health Plan Data Certification Form (MSA 2012)
   - Litigation (limited to litigation directly naming health plan, MSA 129)
   - Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms)
   - Medicaid Provider Directory; **include an electronic copy of the provider directory on compact disc**
   - Medicaid Certificate of Coverage
   - Medicaid Member Handbook
   - **EPSDT Requirements (see page two)**
2. Due on 6/30/10: HEDIS® IDSS and signed and dated Attestation of Accuracy and Public Reporting Authorization (Medicaid letter from NCQA).
3. Due on 7/30/10: HEDIS® Compliance Audit Report and certified auditor's signed and dated Final Audit Statement.
4. If due date is not a business day, reports received on the next business day will be considered timely

Appendix 3
2010 Reporting Requirements for Medicaid Health Plans

EPSDT Settlement Reporting Requirements:

Please submit the following materials as part of the Annual Report due March 1, 2010:

1. **Educational Materials:** Copy of all educational documents used by the plan to inform children/guardians of availability of EPSDT services, age-appropriate immunizations and assistance from the health plan on accessing EPSDT services
2. **Transportation Policy:** Copy of plan's policy/policies that govern administration of the transportation benefit
3. **Incentives:** List and brief description of member incentives offered to increase member utilization of EPSDT services; list and brief description of provider incentives offered to increase provider monitoring of / providing EPSDT services
4. **EPSDT Report Template:** Complete report template

Appendix 4
MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2009 – September 30, 2010)

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and health plans.

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with health plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the Contract **Section 1.022(EE)**.

Appendix 4
MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2009 – September 30, 2010)

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization Status	Fully immunize children who turn two years old during the calendar year.	Combination 2 ≥ 81%	HEDIS® report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥ 84%	HEDIS® report	Annual
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥63%	HEDIS® report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday	≥75% for continuous enrollment	DCH Data Warehouse	Monthly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 60%	Encounter data	Quarterly
• **Access to care:** Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 64%	Encounter data	Quarterly
• **Customer Services:** Enrollee Complaints	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < .25 per 1000 member months	Beneficiary/ Provider contacts tracking (BPCT)	Quarterly

Appendix 4
MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2009 – September 30, 2010)

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Claims Reporting and Processing**	Health plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, and ≤1.75% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting (Institutional, Professional)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	DCH Data Exchange Gateway (DEG) and DCH Data Warehouse	Monthly
• **Encounter Data Reporting (Pharmacy)**	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	DCH Data Exchange Gateway (DEG) and DCH Data Warehouse	Monthly
• **Provider File Reporting**	Timely and accurate provider file update/submission before the last Friday of the month	Timely and Complete submission	MI Enrolls	Monthly

Appendix 5
Performance Bonus Template

Category	Description	Payout 1* Report due: 6/10 Projected payout: 7/10	Payout 2* Report due: 11/10 Projected payout: 12/10
Patient Centered Medical Home (PCMH) **3.0 Million**	The Health Plan actively supports engagement and transition of primary care practices to Patient Centered Medical Homes by aligning provider incentive programs with two of the three★ FY 2010 PCMH focus areas: • ePrescribing • Patient Registry • Expanded Access ★NOTE: FY 2011 P4P will include all three focus areas.	MHP develops and submits a strategic plan to incorporate PCMH elements into provider incentive program/payments. The ePrescribing incentive should reward providers for implementing/utilizing an application that allows the prescriber to do all of the following: • Electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care. • Perform eligibility and formulary queries between prescribers and Health Plan • Obtain medication history The patient registry incentive should reward primary care practices for: • Implementation and active use of an electronic registry that captures key demographic and clinical information for all patients in the practice with a selected condition or to track selected preventive services. The expanded access incentive should reward primary care practices for: • Accessibility and availability outside of 8-5 business hours through 24 on call clinician, e-appointments, and/or office hours before 8AM/ after 5, weekends and evenings.	MHP report will: • Identify provider groups that are targeted for incentive program • Describe their P4P program for each focus area • Identify amount targeted for PCMH payout • Provide documentation that verifies plan efforts in applicable focus area. (i.e., reports/screen shots from e-prescribe interface, de-identified reports from patient registry, reminder/recall letters from patient registry)

Category	Description	Payout 1* Report due: 6/10 Projected payout: 7/10	Payout 2* Report due: 11/10 Projected payout: 12/10
ePrescribing **1.5 Million**	The Health Plan is connected to Surescripts® and exchanges key clinical and demographic enrollee information to support provider adoption and use of electronic prescribing.	Sure Scripts® provides MDCH with confirmation that Medicaid Health Plan/PBM is connected with SureScripts® **and** health plan/PBM provides ePrescribing transactions (eligibility, drug history and formulary information) for their Medicaid line of business.	Health Plan provides minimum six months trended volume statistics for: • ePrescribing eligibility transactions • ePrescribing Drug history transactions
		Health Plan modifies Rx billing procedures (as applicable) to require reporting of Prescription Origin Code by network pharmacy providers in order to have a mechanism to collect and produce the volume of paid prescriptions that were ePrescribed.	Health Plan provides minimum six months trended volume statistics for: • Volume and percentage of paid prescriptions that were e-prescribed
Behavioral Health: **Care Coordination** **1.5 Million**	Behavioral health care coordination refers to processes that link the primary care and behavioral health providers of Medicaid managed care enrollees served by PIHPs. Care coordination processes may include: • Care planning strategies • Integration of primary and behavioral health care • Exchange of clinical information	MHP quality improvement plan includes a new 2010 initiative focused on behavioral health coordination for **persons with SMI.**	Provide written description of care coordination initiative including: • Targeted enrollee population, primary care providers, and PIHP providers • Interventions • YTD results (data)
Specialty Access: **Administrative Compliance** **1.0 Million**	The Specialty Network Access referral process was established to increase the availability of selected specialty providers affiliated with public entities (PE). The referral process requires adherence to a common procedure and reporting of common data elements.	Health Plan utilizes common referral from when utilizing specialty providers affiliated with a PE. Health plans should report total number of referrals by PE for the period October 2009 –March, 2010.	Health Plan utilizes common referral from when utilizing specialty providers affiliated with a PE. Health plans should report total number of referrals by PE for the period April 2010 –September 2010.

Category	Description	Payout 1* Report due: 6/10 Projected payout: 7/10	Payout 2* Report due: 11/10 Projected payout: 12/10
Healthy Lifestyles: Tobacco Cessation **.5 Million**	The Healthy Lifestyle Screening questionnaire is administered by phone on a monthly basis to newly enrolling Medicaid beneficiaries using the Mi Enrolls phone line to enroll in a health plan. The questionnaire includes tobacco use status and interest in seeking help in quitting. The Medicaid Health Plan receives an electronic file of survey results for beneficiaries who have completed the survey.	MHP submit plan for identification and outreach to all newly enrolled members who request assistance with tobacco cessation.	Health Plan provides minimum six months trended data for: • Number of newly identified members who request assistance with tobacco cessation • Number of newly enrolled members successfully contacted • Number of newly enrolled that obtain tobacco cessation products and/or counseling within 3 months after contact
Quality Improvement: Selected HEDIS Measures **1.5 Million**	The Health Plan has established quality improvement initiatives focused on improvement in the following selected HEDIS measures: • Controlling High BP • Appropriate Testing for Children with Pharyngitis • Appropriate Treatment for Children with URI	MHP quality improvement plan includes interventions focused on the three selected HEDIS measures.	The Health HEDIS 2009 Report* indicates a Reportable score for the selected measures. *Note: Plan is exempted from this requirement if no HEDIS report available if plan did not hold a MHP contract prior to 10-1-09 or membership too small to report measure.

Health Plan Name	FY 10 Performance Bonus Template		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2009 HEDIS	**2009 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Smoking Cessation Strategies		0	0.0%	0.0%	0.0%
Advising Smokers to Quit		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 0 visits		0	0.0%	0.0%	0.0%
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Immunizations					
Childhood - Combo 2		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2009 HEDIS	**2008 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%
7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	**Last CAHPS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%****	**75%****	**90%****
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%
		Average (1 point) Above Average(2 points)	**Average**	**Above Average**	
Getting Needed Care- Child		0			
Getting Care Quickley-Child		0			
Health Plan Rating - Child		0			

Accreditation Status - 2009	**Accredited or Conditional as of 12/31/09 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/09 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/09 (10 Pts)**
Org Name (Date of visit)			
Total Member Months of Enrollment by Age and Sex - HEDIS 2009	**0**		

Summary	**Possible Points**	**Health Plan Points**
Clinical Measures (42.0%)	68	0.0
Access to Care (15.0%)	24	0.0
Survey Measures (CAHPS) (13.0%)	22	0.0
Accreditation Status (6.0%)	10	0.0
Focus Study Requirements (24.0%)	40	0.0
Performance Bonus Total Score	**164**	**0.0**

DCH Focus Study (Total 40 Pt.)	**Score**	**Incentive Points**
ABCD	0.0%	0.0
BMI	0.0%	0.0
Total Points		

CAHPS Survey Measures

**** based on 2009 NCQA Quality Compass Public Report Rate.**

2010 Template

Attachment A
Contractor's Approved Service Areas

Oakland
Wayne

Attachment B
Contractor's Awarded Rates

Note: The attached State of Michigan Fiscal Year 2009 Managed Care Rates (effective July 1, 2009) are the effective rates until the State of Michigan's Fiscal Year 2010 budget is approved. A contract amendment will be issued when the new rates are approved. Also, please disregard the regions referenced on the attached rate sheets. Please reference Attachment A for the new contract Service Areas.

State of Michigan Managed Care Rates FY09
Effective Date 7/1/2009

Omnicare 0004618768 0004618777; County 82

Region 01

Rate Cell		Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	Adj Base Rate with MBT	0.19% Bonus W/H	Rate after W/H
1	TANF	< 1		M	473.04	163.96	31.75	4.60	673.35	0.996			670.66	675.35	-1.28	674.07
2	TANF	< 1		F	437.30	127.18	28.18	4.60	597.26	0.996			594.87	599.03	-1.14	597.89
3	TANF	1 - 4		M	87.82	21.48	1.89	4.60	115.79	0.996			115.33	116.14	-0.22	115.92
4	TANF	1 - 4		F	71.94	14.75	1.40	4.60	92.69	0.996			92.32	92.97	-0.18	92.79
5	TANF	5 - 14		M	56.83	9.96	0.78	4.60	72.17	0.996			71.88	72.38	-0.14	72.24
6	TANF	5 - 14		F	48.97	8.56	0.69	4.60	62.82	0.996			62.57	63.01	-0.12	62.89
7	TANF	15 - 20		M	58.76	14.21	1.43	4.60	79.00	0.996			78.68	79.23	-0.15	79.08
8	TANF	15 - 20		F	88.15	17.73	1.67	4.60	112.15	0.996			111.70	112.48	-0.21	112.27
9	TANF	21 - 25		M	95.84	30.02	2.99	4.60	133.45	0.996			132.92	133.85	-0.25	133.60
10	TANF	21 - 25		F	162.02	42.48	4.56	4.60	213.66	0.996			212.81	214.30	-0.41	213.89
11	TANF	26 - 44		M	217.78	63.61	8.78	4.60	294.77	0.996			293.59	295.65	-0.56	295.09
12	TANF	26 - 44		F	228.16	62.88	6.65	4.60	302.29	0.996			301.08	303.19	-0.58	302.61
13	TANF	45 +		M	415.86	116.04	17.10	4.60	553.60	0.996			551.39	555.25	-1.05	554.20
14	TANF	45 +		F	424.35	128.02	15.64	4.60	572.61	0.996			570.32	574.31	-1.09	573.22
15	ABAD	0 - 20		M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
16	ABAD	0 - 20		F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
17.1	ABAD	21 - 39	Medicare	M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
18.1	ABAD	21 - 39	Medicare	F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
17.2	ABAD	21 - 39		M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
18.2	ABAD	21 - 39		F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
19.1	ABAD	40 - 64	Medicare	M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
20.1	ABAD	40 - 64	Medicare	F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
19.2	ABAD	40 - 64		M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
20.2	ABAD	40 - 64		F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
21.1	ABAD	65 +	Medicare	M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
22.1	ABAD	65 +	Medicare	F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
21.2	ABAD	65 +		M	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
22.2	ABAD	65 +		F	657.45	200.74	30.12	9.21	897.52		0.985		884.06	890.25	-1.69	889.00
23.1	OAA	0 +	Medicare	M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.1	OAA	0 +	Medicare	F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
23.2	OAA	0 +		M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.2	OAA	0 +		F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
59.9	rMCR	0 +		F	4,340.07	1,827.33	490.88	0.00	6,658.28				6,658.28	6,704.89	-12.74	6,692.00

NOTE: Due to MDCH Medicaid claims system limitations, ABAD (Rate Cells 15 - 22.2) and MCR (Rate Cell 59.9) are rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY09
Effective Date 7/1/2009

Omnicare 0004618768 0004618777; County 50

Region 09

Rate Cell		Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	Adj Base Rate with MBT	0.19% Bonus W/H	Rate after W/H
1	TANF	< 1		M	473.04	163.96	31.75	4.60	673.35	0.998			672.00	676.70	-1.29	675.41
2	TANF	< 1		F	437.30	127.18	28.18	4.60	597.26	0.998			596.07	600.24	-1.14	599.10
3	TANF	1 - 4		M	87.82	21.48	1.89	4.60	115.79	0.998			115.56	116.37	-0.22	116.15
4	TANF	1 - 4		F	71.94	14.75	1.40	4.60	92.69	0.998			92.50	93.15	-0.18	92.97
5	TANF	5 - 14		M	56.83	9.96	0.78	4.60	72.17	0.998			72.03	72.53	-0.14	72.39
6	TANF	5 - 14		F	48.97	8.56	0.69	4.60	62.82	0.998			62.69	63.13	-0.12	63.01
7	TANF	15 - 20		M	58.76	14.21	1.43	4.60	79.00	0.998			78.84	79.39	-0.15	79.24
8	TANF	15 - 20		F	88.15	17.73	1.67	4.60	112.15	0.998			111.93	112.71	-0.21	112.50
9	TANF	21 - 25		M	95.84	30.02	2.99	4.60	133.45	0.998			133.18	134.11	-0.25	133.86
10	TANF	21 - 25		F	162.02	42.48	4.56	4.60	213.66	0.998			213.23	214.72	-0.41	214.31
11	TANF	26 - 44		M	217.78	63.61	8.78	4.60	294.77	0.998			294.18	296.24	-0.56	295.68
12	TANF	26 - 44		F	228.16	62.88	6.65	4.60	302.29	0.998			301.69	303.80	-0.58	303.22
13	TANF	45 +		M	415.86	116.04	17.10	4.60	553.60	0.998			552.49	556.36	-1.06	555.30
14	TANF	45 +		F	424.35	128.02	15.64	4.60	572.61	0.998			571.46	575.46	-1.09	574.37
15	ABAD	0 - 20		M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
16	ABAD	0 - 20		F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
17.1	ABAD	21 - 39	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
18.1	ABAD	21 - 39	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
17.2	ABAD	21 - 39		M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
18.2	ABAD	21 - 39		F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
19.1	ABAD	40 - 64	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
20.1	ABAD	40 - 64	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
19.2	ABAD	40 - 64		M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
20.2	ABAD	40 - 64		F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
21.1	ABAD	65 +	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
22.1	ABAD	65 +	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
21.2	ABAD	65 +		M	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
22.2	ABAD	65 +		F	657.45	200.74	30.12	9.21	897.52		1.049		941.50	948.09	-1.80	946.00
23.1	OAA	0 +	Medicare	M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.1	OAA	0 +	Medicare	F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
23.2	OAA	0 +		M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.2	OAA	0 +		F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
59.9	rMCR	0 +		F	4,180.99	1,827.33	490.88	0.00	6,499.20				6,499.20	6,544.69	-12.43	6,532.00

NOTE: Due to MDCH Medicaid claims system limitations, ABAD (Rate Cells 15 - 22.2) and MCR (Rate Cell 59.9) are rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY09
Effective Date 7/1/2009

Omnicare 0004618768, 0004618777; County 63

Region 10

Rate Cell		Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	Adj Base Rate with MBT	0.19% Bonus W/H	Rate after W/H
1	TANF	< 1		M	473.04	163.96	31.75	4.60	673.35	1.022			688.16	692.98	-1.32	691.66
2	TANF	< 1		F	437.30	127.18	28.18	4.60	597.26	1.022			610.40	614.67	-1.17	613.50
3	TANF	1 - 4		M	87.82	21.48	1.89	4.60	115.79	1.022			118.34	119.17	-0.23	118.94
4	TANF	1 - 4		F	71.94	14.75	1.40	4.60	92.69	1.022			94.73	95.39	-0.18	95.21
5	TANF	5 - 14		M	56.83	9.96	0.78	4.60	72.17	1.022			73.76	74.28	-0.14	74.14
6	TANF	5 - 14		F	48.97	8.56	0.69	4.60	62.82	1.022			64.20	64.65	-0.12	64.53
7	TANF	15 - 20		M	58.76	14.21	1.43	4.60	79.00	1.022			80.74	81.31	-0.15	81.16
8	TANF	15 - 20		F	88.15	17.73	1.67	4.60	112.15	1.022			114.62	115.42	-0.22	115.20
9	TANF	21 - 25		M	95.84	30.02	2.99	4.60	133.45	1.022			136.39	137.34	-0.26	137.08
10	TANF	21 - 25		F	162.02	42.48	4.56	4.60	213.66	1.022			218.36	219.89	-0.42	219.47
11	TANF	26 - 44		M	217.78	63.61	8.78	4.60	294.77	1.022			301.25	303.36	-0.58	302.78
12	TANF	26 - 44		F	228.16	62.88	6.65	4.60	302.29	1.022			308.94	311.10	-0.59	310.51
13	TANF	45 +		M	415.86	116.04	17.10	4.60	553.60	1.022			565.78	569.74	-1.08	568.66
14	TANF	45 +		F	424.35	128.02	15.64	4.60	572.61	1.022			585.21	589.31	-1.12	588.19
15	ABAD	0 - 20		M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
16	ABAD	0 - 20		F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
17.1	ABAD	21 - 39	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
18.1	ABAD	21 - 39	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
17.2	ABAD	21 - 39		M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
18.2	ABAD	21 - 39		F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
19.1	ABAD	40 - 64	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
20.1	ABAD	40 - 64	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
19.2	ABAD	40 - 64		M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
20.2	ABAD	40 - 64		F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
21.1	ABAD	65 +	Medicare	M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
22.1	ABAD	65 +	Medicare	F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
21.2	ABAD	65 +		M	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
22.2	ABAD	65 +		F	657.45	200.74	30.12	9.21	897.52		1.008		904.70	911.03	-1.73	909.00
23.1	OAA	0 +	Medicare	M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.1	OAA	0 +	Medicare	F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
23.2	OAA	0 +		M	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
24.2	OAA	0 +		F	657.45	200.74	30.12	9.21	897.52			0.758	680.32	685.08	-1.30	683.78
59.9	rMCR	0 +		F	4,319.10	1,827.33	490.88	0.00	6,637.31				6,637.31	6,683.77	-12.70	6,671.00

NOTE: Due to MDCH Medicaid claims system limitations, ABAD (Rate Cells 15 - 22.2) and MCR (Rate Cell 59.9) are rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY09
Effective Date 7/1/2009

Omnicare 0004618768 0004618777; County 99

Region SW

Rate Cell		Description		Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	Adj Base Rate with MBT	0.19% Bonus W/H	Rate after W/H
1	TANF	< 1		M	469.97	146.76	29.81	4.60	651.14	1.000			651.14	655.70	-1.25	654.45
2	TANF	< 1		F	426.90	123.53	26.93	4.60	581.96	1.000			581.96	586.03	-1.11	584.92
3	TANF	1 - 4		M	85.44	20.84	1.79	4.60	112.67	1.000			112.67	113.46	-0.22	113.24
4	TANF	1 - 4		F	71.77	15.25	1.38	4.60	93.00	1.000			93.00	93.65	-0.18	93.47
5	TANF	5 - 14		M	62.48	10.46	0.80	4.60	78.34	1.000			78.34	78.89	-0.15	78.74
6	TANF	5 - 14		F	53.45	8.93	0.66	4.60	67.64	1.000			67.64	68.11	-0.13	67.98
7	TANF	15 - 20		M	65.48	15.16	1.46	4.60	86.70	1.000			86.70	87.31	-0.17	87.14
8	TANF	15 - 20		F	103.49	21.23	1.76	4.60	131.08	1.000			131.08	132.00	-0.25	131.75
9	TANF	21 - 25		M	100.44	29.28	2.68	4.60	137.00	1.000			137.00	137.96	-0.26	137.70
10	TANF	21 - 25		F	182.80	46.78	4.04	4.60	238.22	1.000			238.22	239.89	-0.46	239.43
11	TANF	26 - 44		M	228.54	73.00	7.23	4.60	313.37	1.000			313.37	315.56	-0.60	314.96
12	TANF	26 - 44		F	251.60	65.59	6.62	4.60	328.41	1.000			328.41	330.71	-0.63	330.08
13	TANF	45 +		M	426.58	116.93	16.48	4.60	564.59	1.000			564.59	568.54	-1.08	567.46
14	TANF	45 +		F	445.98	123.16	15.50	4.60	589.24	1.000			589.24	593.36	-1.13	592.23
15	ABAD	0 - 20		M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
16	ABAD	0 - 20		F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
17.1	ABAD	21 - 39	Medicare	M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
18.1	ABAD	21 - 39	Medicare	F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
17.2	ABAD	21 - 39		M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
18.2	ABAD	21 - 39		F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
19.1	ABAD	40 - 64	Medicare	M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
20.1	ABAD	40 - 64	Medicare	F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
19.2	ABAD	40 - 64		M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
20.2	ABAD	40 - 64		F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
21.1	ABAD	65 +	Medicare	M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
22.1	ABAD	65 +	Medicare	F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
21.2	ABAD	65 +		M	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
22.2	ABAD	65 +		F	638.07	179.49	25.67	9.21	852.44		1.000		852.44	858.41	-1.63	857.00
23.1	OAA	0 +	Medicare	M	638.07	179.49	25.67	9.21	852.44			0.805	686.21	691.01	-1.31	689.70
24.1	OAA	0 +	Medicare	F	638.07	179.49	25.67	9.21	852.44			0.805	686.21	691.01	-1.31	689.70
23.2	OAA	0 +		M	638.07	179.49	25.67	9.21	852.44			0.805	686.21	691.01	-1.31	689.70
24.2	OAA	0 +		F	638.07	179.49	25.67	9.21	852.44			0.805	686.21	691.01	-1.31	689.70
59.9	rMCR	0 +		F	4,044.13	1,660.57	450.96	0.00	6,155.66				6,155.66	6,198.75	-11.78	6,187.00

NOTE: Due to MDCH Medicaid claims system limitations, ABAD (Rate Cells 15 - 22.2) and MCR (Rate Cell 59.9) are rounded to nearest whole dollar after the bonus withhold.