

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

December 17, 2008

CHANGE NOTICE NO. 14
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331 wgreidenbaugh@magellan.com		VENDOR NUMBER/MAIL CODE
		BUYER/CA (517) 241-1916 Jim Wilson
Contract Administrator: Susan Kant (517) 335-3068 Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS		
CONTRACT PERIOD: From: March 1, 2001 To: January 31, 2009		
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, this Contract is hereby **EXTENDED** through **January 31, 2009**.
 Additionally, effective **January 1, 2009**, the Administrative Fee is changed to **\$2.34**.
 All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: \$33,471,000.00

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

September 25, 2008

CHANGE NOTICE NO. 13
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331 wgreidenbaugh@magellan.com		VENDOR NUMBER/MAIL CODE
		BUYER/CA (517) 373-1080 Melissa Castro
Contract Administrator: Susan Kant (517) 335-3068 Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS		
CONTRACT PERIOD:		
	From: March 1, 2001	To: October 31, 2008
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, this Contract is hereby **EXTENDED** through **October 31, 2008**.
 All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: \$33,471,000.00

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

February 13, 2008

**CHANGE NOTICE NO. 12
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER/CA (517) 373-1080 Melissa Castro
Contract Administrator: Susan Kant (517) 335-3068 Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS		
CONTRACT PERIOD: From: March 1, 2001 To: September 30, 2008		
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, the Network Provider Re-Credentialing Cycle is revised to a three-year cycle. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

November 19, 2007

CHANGE NOTICE NO. 11
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER/CA (517) 373-1080 Melissa Castro
Contract Administrator: Susan Kant (517) 335-3068		
Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS		
CONTRACT PERIOD: From: March 1, 2001		To: September 30, 2008
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, this Contract is hereby EXTENDED through September 30, 2008. Retirees 65 and over who are eligible for Medicare are removed from the scope of this Contract effective January 1, 2008. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

FOR THE VENDOR:

Magellan Behavioral of Michigan

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature
Melissa Castro, CPPB, Buyer Manager

 Name/Title
Services Division, Purchasing Operations

 Division

 Date

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

August 9, 2007

CHANGE NOTICE NO. 10
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331	TELEPHONE James Kinville (248) 848-6866
	VENDOR NUMBER/MAIL CODE
	BUYER/CA (517) 373-1080 Melissa Castro <i>MC</i>
Contract Administrator: Susan Kant (517) 335-3068 Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS	
CONTRACT PERIOD: From: March 1, 2001 To: December 31, 2007	
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, this Contract is hereby EXTENDED through December 31, 2007.
All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

June 29, 2007

**CHANGE NOTICE NO. 9
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR <p style="text-align: center;">Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331</p>	TELEPHONE James Kinville (248) 848-6866 VENDOR NUMBER/MAIL CODE BUYER/CA (517) 373-1080 Melissa Castro
Contract Administrator: Susan Kant (517) 335-3068 <p style="text-align: center;">Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS</p>	
CONTRACT PERIOD: From: March 1, 2001 To: June 30, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately, the Contract Compliance Inspector for this Contract is hereby changed to Susan Kant (517) 335-3068. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

July 18, 2006

**CHANGE NOTICE NO. 8
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331		TELEPHONE James Kinville (248) 848-6866
		VENDOR NUMBER/MAIL CODE
		BUYER/CA (517) 373-1080 Melissa Castro
Contract Administrator: Peggy Moczul Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS		
CONTRACT PERIOD: From: March 1, 2001 To: June 30, 2007		
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>	
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>	
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>		

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby EXTENDED through June 30, 2007. Also, the administrative fee is hereby increased to \$2.51 pepm. All other terms, conditions, specifications and pricing remain unchanged.

Please note: the buyer has been changed to Melissa Castro.

AUTHORITY/REASON:

Per agency and vendor agreement and DMB/Purchasing Operations approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

February 8, 2006

CHANGE NOTICE NO. 7
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Road, Suite #148 Farmington Hills, MI 48331	TELEPHONE James Kinville (248) 848-6866
	VENDOR NUMBER/MAIL CODE
	BUYER (517) 241-1647 Irene Pena, CPPB
Contract Administrator: Peggy Moczul Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – DCS	
CONTRACT PERIOD: From: March 1, 2001 To: September 30, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately this contract is hereby EXTENDED through September 30, 2006 as provided in the extension clause of the original contract.

Pricing, terms & conditions remain the same.

AUTHORITY/REASON:

Per DMB/Acquisition Services and agency contact (Peggy Moczul).

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

May 18, 2005

**CHANGE NOTICE NO. 6
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		TELEPHONE James Kinville (248) 848-6866
		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Peggy Moczul Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees - DCS		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2006		
TERMS N/A	SHIPMENT N/A	
F.O.B. N/A	SHIPPED FROM N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Please note effective immediately this contract is hereby EXTENDED through 4/30/06 as provided in the extension clause of the original contract. The administrative fee remains \$2.42 pepm.

AUTHORITY/REASON:

Per DMB/Acquisition Services and agency contact (Peggy Moczul).

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

March 15, 2004

CHANGE NOTICE NO. 5
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Peggy Moczul Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees - DCS		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2005		
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Please note, effective March 15, 2004 this contract is hereby EXTENDED through April 30, 2005. Also, the ASO rate effective May 1, 2004 through April 30, 2005 will be \$2.42 pepm. Terms and conditions remain the same.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

March 24, 2003

CHANGE NOTICE NO. 4
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331	TELEPHONE James Kinville (248) 848-6866
	VENDOR NUMBER/MAIL CODE
	BUYER (517) 241-1647 Irene Pena
Contract Administrator: Peggy Moczul Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees - DCS	
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options	
TERMS N/A	SHIPMENT N/A
F.O.B. N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A	

NATURE OF CHANGE (S):

The contract administrator is now:

Peggy Moczul, DCS
Director, Employee Benefits Division
Department of Civil Service
(517) 373-1846

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

December 13, 2002

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees Dept. of Management & Budget, Office of State Employer		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options		
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 the following subcontractor will be providing re-credentialing services under this contract:

Aperture Credentialing, Inc.
301 North Hurstbourne Parkway, Suite 200
Louisville, KY 40222

AUTHORITY/REASON:

Per mutual agreement

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

December 6, 2001

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees Dept. of Management & Budget, Office of State Employer		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options		
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 the attached Letter of Agreement between the State of Michigan and Magellan is hereby incorporated into this contract.

AUTHORITY/REASON:

Per mutual agreement

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00

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

January 31, 2001

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B1001212
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE James Kinville (248) 848-6866
Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees Dept. of Management & Budget, Office of State Employer		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options		
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Please note effective April 16, 2001 the attached letter of agreement is hereby incorporated into this contract.

AUTHORITY/REASON:

Per mutual agreement

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00



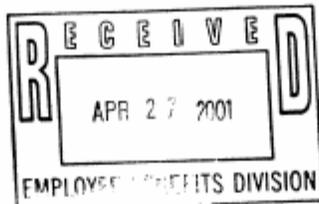
April 16, 2001

Rita Swanson
Director of Employee Benefits Division
Office of State Employer
P.O. Box 30026
Lansing, MI 48909

Dear Rita:

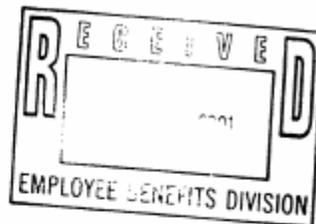
I am writing pursuant to our discussion on April 10, 2001 regarding Magellan's reporting requirements for the State of Michigan account. To summarize our agreement regarding the report specifications:

- The claims lag report is needed on a monthly basis only.
- The paid claims report will not include information on employee copays. It was agreed that employee copay amounts could be extrapolated by the State from the other data provided in the report.
- Detailed claims file to the State's specified vendor (MEDSTAT) needs to be provided only quarterly. MEDSTAT will provide the annual roll-up of this data.
- The "number of reconsideration claims submitted and length of time (in days) to make reconsideration determinations" actually refers to reconsideration of non-authorization determinations (aka denials).
- A determination regarding the requirement for an annual report of claims coordinated, split by claims coordinated with the State-sponsored health plans and by spouse's employer-sponsored medical or MHSA plans is still under consideration. Currently, the Office of the State Employer is unable to provide electronic data for loading coordination of benefit information. (Magellan determined subsequent to the meeting that there is a field in the claims file that captures the COB dollars paid by other plans. However, depending on the outcome of an electronic feed from the State, Magellan would have to analyze the programming costs to accept the feed and provide reports.)
- The measure for phone inquiries and for calls returned and resolved by the Account Service Representative will be changed from *within 24 hours* to *within one business day*.
- The call types to which the performance measures for the Account Service Representative apply exclude eligibility update calls and ID card requests. Magellan will be developing a form/log for tracking these calls, which will be shared during joint meetings.
- Telephone access performance measures will be modified as follows:
 - ♦ Average Speed of Answer will be within 30 seconds; the measures for percentages of calls to be answered within incremental specified time frames have been eliminated.
 - ♦ The standard for the abandonment rate will be 5%, rather than 3%.
 - ♦ The performance standard for blocked calls ($\leq 3\%$) remains unchanged.



James E. Kinville, MA, LLP
President
Michigan Regional Service Center

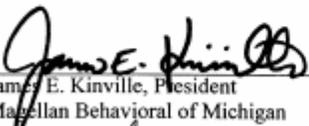
34705 Twelve Mile Road, Suite 148
Farmington Hills, MI 48331
248/848-6866 tel
248/848-7019 fax
jekinville@magellanhealth.com



- The State has requested a copy of Magellan's network disruption report prior to April 26, 2001.
- It was clarified that monthly reports are not required at the end of the quarter (with the exception of the Claims Lag Report) as the data for the third month will be rolled into the quarterly. Likewise, the fourth quarter report will not be required as the fourth quarter data will be reported in the annual report. No quarterly report is required for the current quarter, as the account has been operational with Magellan only for one month of the quarter. In the meeting it was agreed that the third quarter report would be the first one due, and that it would cover four months with the inclusion of the March data. It was also agreed that Magellan would present the annual report at the State's annual meeting.

After further analysis of the performance standard for network site visits following this meeting, Magellan would like to discuss this standard further with the State's representatives at a subsequent meeting.

An updated Report Specifications Grid for the State of Michigan as of April 10, 2001, is enclosed, labeled Attachment A. The signatures below indicate agreement with the terms outlined within this letter and Attachment A. As this will serve as a Letter of Understanding between Magellan and the State of Michigan, I am enclosing two copies with original signatures. Please retain one for your records and return the other to me.



James E. Kinville, President
Magellan Behavioral of Michigan

4/16/01
Date



Rita Swanson, Director
Employee Benefits Division, OSE

5/8/01
Date

Attachment A to Magellan/State of Michigan Letter of Agreement
Magellan Behavioral of Michigan
Report Specifications for State of Michigan (as of April 10, 2001)

Data Element	Standard	Data Source	Report Frequency	Comments
I. Claims Reports				
Claims "lag" report, accumulated year-to-date	NA	Automated reports from the claims systems	Monthly	
<ul style="list-style-type: none"> • Paid claims, split between Actives, COBRA, and Retirees, showing: • number of admissions • days/visits/services • charges • split by network and non-network, and by categories of inpatient and outpatient • 85% of claims processed/ responded to within 10 business days • 99% of claims processed/ responded to within 20 business days 		Automated reports from the claims systems	Monthly, Quarterly, Annually	
<ul style="list-style-type: none"> • Claims accuracy: • financial payment accuracy • payment incidence accuracy • claim processing accuracy 	99% 97% 96%	Manually tracked via audit process	Monthly, Quarterly, Annually	
Detailed claims file provided to the State's specified data vendor	NA	Manually tracked	Quarterly	
Number of subscribers and number of dependents covered, split between Actives, COBRA, and Retirees	NA	Automated reports from the claims system	Monthly, Quarterly, Annually	
Claims coordinated, split by claims coordinated with the State-sponsored health plans, and by spouse ; employer-sponsored medical or MHSA plans	NA	Claims data	Annual	Investigating with claims the ability to report on coordination of benefit.
II. Account Management Reports				
Summary of significant activities, issues or problems	NA	Narrative summary by Account Manager	Monthly, Quarterly, Annually	
Timeliness of ID card distribution	<ul style="list-style-type: none"> • 85% distributed within 10 business days 	Manual tracking process	Quarterly/Annually	

**Attachment A to Magellan/State of Michigan Letter of Agreement
Magellan Behavioral of Michigan
Report Specifications for State of Michigan (as of April 10, 2001)**

Data Element	Standard	Data Source	Report Frequency	Comments
Customer Services Written inquiries	<ul style="list-style-type: none"> 99% accuracy distributed within 15 business days with 99% accuracy 95% responded within 5 business days 100% responded within 10 business days 	Manual tracking process	Quarterly/Annually	
Calls returned by the Account Service Representative	100% within 24 hrs of receipt	Manual tracking process	Quarterly/Annually	Excludes calls regarding eligibility updates and ID card requests.
Calls resolved by the Account Service Representative	50% within 24 hrs by 5/10/5/10	Manual tracking process	Quarterly/Annually	
Account Service Representative Response to written inquiry	<5 business days	Manual tracking process	Quarterly/Annually	
Update of eligibility files	Within 2 business days	Manual tracking process	Quarterly/Annually	
Member Satisfaction Survey	85% of respondents indicate overall satisfaction with Magellan	Magellan Corporate Data Analysis of Satisfaction Survey Responses	Annually	
III. Utilization Management Reports				
Admits per thousand and ALOS split by age groups	NA	Automated reports from the authorization database	Quarterly/Annually	
Number of reconsideration determinations and number of days to make reconsideration determination (Level I Appeals)	NA	Manual tracking process	Quarterly/Annually	
Reversal rate for medical necessity		Manual tracking process	Quarterly/Annually	

**Attachment A to Magellan/State of Michigan Letter of Agreement
Magellan Behavioral of Michigan
Report Specifications for State of Michigan (as of April 10, 2001)**

Data Element	Standard	Data Source	Report Frequency	Comments
decisions (Appeal overturns, all levels)	NA			
Response time (in days) to practitioner's request for authorization	NA	Manual tracking process utilizing a 25% sample of new inpatient, IOP and Partial Hospital cases, measured from date of request for certification to date of certification determination.	Quarterly/Annually	
Time (in days) from admission or referrals to day reviewed (authorized)	NA	Manual tracking process utilizing a 25% sample of new inpatient, IOP and Partial Hospital cases, measured from date of actual admission/start to date of request for certification.	Quarterly/Annually	
Individualized case management cases: <ul style="list-style-type: none"> number and cost of case management activities, referencing the type of provider utilized, focus of task, and amount of savings achieved number and percent of total cases in case management that resulted in alternative treatments. 	NA	Manual tracking of cases by the account manager for whom individualized case management services have been implemented.	Quarterly, Annually	
IV. Network Management Reports				
Network quality: <ul style="list-style-type: none"> number of complaints made and number resolved number of providers identified as requiring further investigation number of providers for which more details were requested and are currently pending, with number concluded with no adverse 		Manual tracking from complaint and provider performance, inquiry and review data	Quarterly/Annually	

**Attachment A to Magellan/State of Michigan Letter of Agreement
Magellan Behavioral of Michigan
Report Specifications for State of Michigan (as of April 10, 2001)**

Data Element	Standard	Data Source	Report Frequency	Comments
<ul style="list-style-type: none"> percent of providers reviewed in monitoring patterns of abuse average time from identification of the problem to conclusion of the investigation 				
Number of providers and ratio of providers to claims	NA	Top 100 Provider Report from claims data	Quarterly	Will show claims count and claims paid for the top 100 providers based on claims data.
Urban par providers in-network	95% within 5 miles	Automated Reporting (GeoNetworks®)	Quarterly/Annually	
Suburban par providers in-network	95% within 10 miles	Automated Reporting (GeoNetworks®)	Quarterly/Annually	
Rural par providers in-network	80% within 20 miles	Automated Reporting (GeoNetworks®)	Quarterly/Annually	
Provider on-site audits	7% of par providers audited annually*	Manual tracking process	Quarterly/Annually	*To be reviewed/discussed further
V. Call Management Reports				
Average Speed of Answer (ASA)	≤ 30 seconds		Quarterly/Annually	
Phone Inquiries	100% returned with in one business day	Manual tracking.	Quarterly/Annually	
Abandoned Calls	≤ 5%	Automated telephone reports.	Quarterly/Annually	
Blocked Calls	≤ 3%	Automated telephone reports.	Quarterly/Annually	
VI. Report Delivery Schedule				
Monthly Reports	Due 30 days from end of reporting period	NA		The third monthly report of any quarter will be included with the quarterly.
Quarterly Reports	Due 60 days from end of reporting period			The first quarterly report due from Magellan for

**Attachment A to Magellan/State of Michigan Letter of Agreement
Magellan Behavioral of Michigan
Report Specifications for State of Michigan (as of April 10, 2001)**

Data Element	Standard	Data Source	Report Frequency	Comments
Annual Report	Due 90 days from the end of the SOM fiscal year			2001 is due August 30, 2001. The fourth quarter report will be incorporated into the annual report.

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

January 31, 2001

**CHANGE NOTICE NO. 1
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR <p style="text-align: center;">Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331</p>	TELEPHONE James Kinville (248) 848-6866 VENDOR NUMBER/MAIL CODE BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees Dept. of Management & Budget, Office of State Employer	
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately, the attached transition agreement is hereby incorporated into this contract.

AUTHORITY/REASON:

Per mutual agreement.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$33,471,000.00



James E. Kinville, M.A., L.L.P.
President

34705 West Twelve Mile Road
Suite 148
Farmington Hills, MI 48331
248/848-6866 tel • 248/848-7019 fax
jekinville@magellanhealth.com

October 22, 2001

Ms. Rita Swanson, CEBS
Director, Employee Benefits Division
Office of the State Employer
P.O. Box 30026
Lansing, MI 48909

Dear Ms. Swanson:

As a follow up to our recent discussions regarding Magellan's responsibility for claims payment on Mental Health/Substance Abuse services prior to March 1, 2001, we have agreed on the following:

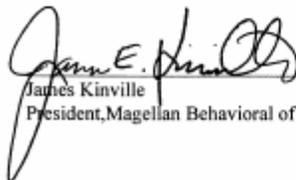
- Effective September 2001, Magellan will assume the responsibility of claims payment for services rendered prior to March 1, 2001. Prior to September 1, 2001 this activity was the responsibility of Value Options.
- Due to the unanticipated and outstanding number of claims that we received from Value Options in September, the State of Michigan has agreed to waive the contractual performance standards associated with claims performance. The time period will be September 1, 2001 through December 31, 2001.

The signatures below will indicate agreement with the above. This letter will serve as a Letter of Understanding between Magellan and the State of Michigan. I am enclosing two copies with original signatures, please retain one for your record and return the other to me. Thanks.



Rita Swanson
Director, Employee Benefits Division

10/25/01
Date



James Kinville
President, Magellan Behavioral of Michigan, Inc.

10/22/01
Date

- ValueOptions will continue to process claims incurred prior to March 1, 2001 until September 1, 2001, after which any remaining claims incurred prior to March 1, 2001 will be turned over to Magellan for processing.
- The State of Michigan agrees to participate in provider forums sponsored by Magellan.
- Magellan will mail I.D. cards and benefit booklets to all members of the State Health Plan by February 15, 2001.
- Magellan will have their dedicated toll free number staffed by February 15, 2001.
- Magellan will have their provider directory on their website by ~~February 15, 2001~~, and agree to update their website weekly thereafter. ^{opt} FEBRUARY 28, 2001

For Magellan Behavioral Health:

JAMES E. KINVILLE

James E. Kinville

1/11/01
Date

For ValueOptions:

C. regg A. Metzello

01/18/2001
Date

For the State of Michigan:

Pete Swanson

1/22/01
Date

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

January 8, 2001

**NOTICE
 TO
 CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331		TELEPHONE James Kinville (248) 848-6866
		VENDOR NUMBER/MAIL CODE
		BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees Dept. of Management & Budget, Office of State Employer		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options		
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 ITB #071I0000484, this Contract Agreement and the vendor's quote dated 7/25/00. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Cost of This Contract: 1st Year \$11,157,000.00

Total Contract Period Estimated Contract Cost: \$33,471,000.00

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

**CONTRACT NO. 071B1001212
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR <p style="text-align: center;">Magellan Behavioral of Michigan 34705 West 12 Mile Rd., Suite 148 Farmington Hills, MI 48331</p>		TELEPHONE James Kinville (248) 848-6866 VENDOR NUMBER/MAIL CODE BUYER (517) 241-1647 Irene Pena
Contract Administrator: Rita Swanson Insurance Services – Mental Health/Substance Insurance for Active & Retired State Employees – Dept. of Management & Budget, Office of State Employer		
CONTRACT PERIOD: From: March 1, 2001 To: April 30, 2004 with up to two one year extension options		
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 ITB #07110000484, this Contract Agreement and the vendor's quote dated 7/25/00. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence. Estimated Cost of This Contract: 1st Year \$11,157,000.00 Total Contract Period Estimated Contract Cost: \$33,471,000.00		

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No. 07110000484. A Purchase Order Form will be issued only as the requirements of the State Departments are submitted to the Office of Purchasing. Orders for delivery may be issued directly by the State Departments through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:	FOR THE STATE:
Firm Name	Signature
Authorized Agent Signature	David F. Ancell
Authorized Agent (Print or Type)	Name
Date	State Purchasing Director
	Title
	Date

SECTION I

CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE OF SOLICITATION

The purpose of this Contract is to obtain quotations for providing managed Mental Health and Substance Abuse Preferred Provider Organization (MHSA PPO) services for eligible state employees, retirees, and dependents, on behalf of the State. The plan is to be effective March 1, 2001. The selected services provider must provide all staffing, systems and procedures required to perform the services described herein.

Administrative fees for the contract awarded from this solicitation will be priced on a **fee per employee/retiree (combined) per month** basis.

I-B TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by any bidder prior to signing of a Contract by all parties. The activities in the proposed Contract cover the three-year period March 1, 2001 to April 30, 2004, with up to two, one-year extensions beyond this period. The State fiscal year is October 1st through September 30th. The Contractor should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

I-C ISSUING OFFICE

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Office of Purchasing, hereafter known as the Office of Purchasing, for the State of Michigan, Employee Benefits Division, Office of State Employer. Where actions are a combination of those of the Office of Purchasing and Office of State Employer, the authority will be known as the State.

The Office of Purchasing is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services described herein. The Office of Purchasing is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract. The OFFICE OF PURCHASING will remain the SOLE POINT OF CONTACT throughout the procurement process, until such time as the Director of Purchasing shall direct otherwise in writing. See Paragraph II-C below. All communications concerning this procurement must be addressed to:

Irene Pena, Buyer
Technical and Professional Services Division
DMB, Office of Purchasing
2nd Floor, Mason Building
P.O. Box 30026
Lansing, MI 48909

I-D CONTRACT ADMINISTRATOR

Upon receipt at the Office of Purchasing of the properly executed Contract Agreement, it is anticipated that the Director of Purchasing will direct that the person named below or any other

person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of any Contract resulting from this Request implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by the Office of Purchasing. The Contract Administrator for this project is:

Rita Swanson
Director, Employee Benefits Division
Office of State Employer
Department of Management and Budget
500 Knapps Centre
P.O. Box 30026
Lansing, MI 48909

I-E COST LIABILITY

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of any Contract. Total liability of the State is limited to the terms and conditions of any resulting Contract.

I-F CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities offered in this proposal whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including but not limited to payment of any and all costs resulting from the anticipated Contract. If any part of the work is to be subcontracted, there should include a list of subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

I-G NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will 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 program are to be released without prior approval of the State and then only to persons designated.

I-H DISCLOSURE

All information in a bidder's proposal and this Contract is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, *et seq.*

I-I ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Department of Auditor General at any time during the Contract period and any

extension thereof, and for three (3) years from the expiration date and final payment on the Contract or extension thereof.

I-J INDEMNIFICATION

1. General Indemnification

The Contractor shall indemnify, defend and hold harmless the State from and against all lawsuits, liabilities, damages and claims or any other proceeding brought against the State by any third party (which for the purposes of this provision shall include, but not be limited to, employees of the State, the Contractor and any of its subcontractors), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

- (a) any breach of this Contract or negligence or intentional tortious act by the Contractor or any of its subcontractors, or by anyone else for whose acts any of them may be liable, in the performance of this Contract;
- (b) the death or bodily injury of any person or the damage, loss or destruction of any real or personal property in connection with the performance of this Contract by the Contractor, or any of its subcontractors, or by anyone else for whose acts any of them may be liable provided, and to the extent that the injury or damage was caused by the fault or negligence of the Contractor.
- (c) any act or omission of the Contractor or any of its subcontractors in their capacity as an employer in the performance of this Contract;
- (d) any claim, demand, action or legal proceeding against the State arising out of or related to occurrences, if any, that the Contractor is required to insure against as provided in this Contract.

2. Indemnification Obligation Not Limited

In any and all claims against the State by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall 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 benefits acts, or any other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, 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 subclause.

3. Continuation of Indemnification Obligation

The duty to indemnify will continue 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 prior to expiration or cancellation.

I-K LIMITATION OF LIABILITY

Except as set forth herein, neither the Contractor nor the State shall be liable to the other party for indirect or consequential damages, even if such party has been advised of the possibility of

such damages. Such limitation as to indirect or consequential damages shall not be applicable for claims arising out of gross negligence, willful misconduct, or Contractor's indemnification responsibilities to the State as set forth in Section I-J with respect to third party claims, action and proceeding brought against the State.

I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS

The Contractor warrants that in performing the services called for by this Contract it will not violate any applicable law, rule, or regulation, any contracts with third parties, or any intellectual rights of any third party, including but not limited to, any United States patent, trademark, copyright, or trade secret.

I-M WARRANTIES AND REPRESENTATIONS

1. The Contractor warrants that all services required to be provided under this Contract shall be furnished in a professional and workmanlike manner, by the Contractor, its subcontractors and its or their employees, having the skill commensurate with the requirements of this Contract.
2. The Contractor warrants that it or its subcontractor is the lawful owner or licensee of any software programs or other material used by the either in the performance of services called for in this Contract, and has all the rights necessary to convey to the State the unencumbered ownership or licensed use of any and all materials or deliverables required to be provided by the terms of this Contract.

I-N TIME IS OF THE ESSENCE

The Contractor agrees that time is of the essence in the performance of the Contractor's obligations under this Contract.

I-O KEY PERSONNEL

The State reserves the right to approve the Contractor's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State.

The Contractor shall not remove or reassign, without the State's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of the Contractor's obligations under this Contract. The Contractor agrees that the continuity of Key Personnel is critical and agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable control of the Contractor including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

The Contractor is asked to name and supply background information on the Key Personnel.

For purposes of this MHSA PPO contract, Key Personnel include:

- The Account Manger,
- The Service Manager, and
- The Clinical Director for the State MHSA PPO program.

I-P WORK PRODUCT AND OWNERSHIP

1. Work Products shall be considered works made by the Contractor for hire by the State and shall belong exclusively to the State and its designees, unless specifically provided otherwise by mutual agreement of the Contractor and the State. If by operation of law any of the Work Product, including all related intellectual property rights, is not owned in its entirety by the State automatically upon creation thereof, the Contractor agrees to assign, and hereby assigns to the State and its designees the ownership of such Work Product, including all related intellectual property rights. The Contractor agrees to provide, at no additional charge, any assistance and to execute any action reasonably required for the State to perfect its intellectual property rights with respect to the aforementioned Work Product.
2. Notwithstanding any provision of this Contract to the contrary, any preexisting work or materials including, but not limited to, any routines, libraries, tools, methodologies, processes or technologies (collectively, the "Development Tools") created, adapted or used by the Contractor in its business generally, including any all associated intellectual property rights, shall be and remain the sole property of the Contractor, and the State shall have no interest in or claim to such preexisting work, materials or Development Tools, except as necessary to exercise its rights in the Work Product. Such rights belonging to the State shall include, but not be limited to, the right to use, execute, reproduce, display, perform and distribute copies of and prepare derivative works based upon the Work Product, and the right to authorize others to do any of the foregoing, irrespective of the existence therein of preexisting work, materials and Development Tools, except as specifically limited herein.
3. The Contractor and its subcontractors shall be free to use and employ their general skills, knowledge and expertise, and to use, disclose, and employ any generalized ideas, concepts, knowledge, methods, techniques or skills gained or learned during the course of performing the services under this Contract, so long as the Contractor or its subcontractors acquire and apply such information without disclosure of any confidential or proprietary information of the State, and without any unauthorized use or disclosure of any Work Product resulting from this Contract.

I-Q CONFIDENTIALITY OF DATA AND INFORMATION

1. All financial, statistical, personnel, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.
2. The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by

the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State. Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

I-R REMEDIES FOR BREACH OF CONFIDENTIALITY

The Contractor acknowledges that a breach of its confidentiality obligations as set forth in section I-Q of this Contract, shall be considered a material breach of the Contract. Furthermore the Contractor acknowledges that in the event of such a breach the State shall be irreparably harmed. Accordingly, if a court should find that the Contractor has breached or attempted to breach any such obligations, the Contractor will not oppose the entry of an appropriate order restraining it from any further breaches or attempted or threatened breaches. This remedy shall be in addition to and not in limitation of any other remedy or damages provided by law.

I-S CONTRACTOR'S LIABILITY INSURANCE

The Contractor shall purchase and maintain such insurance as will protect him/her from claims set forth below which may arise out of or result from the Contractor's operations under the Contract (Purchase Order), whether such operations be by himself/herself or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:

- (1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other State the Contractor shall have insurance or participate in a mandatory State fund to cover the benefits payable to any such employee.
- (2) Claims for damages because of bodily injury, occupational sickness or disease, or death of his/her employees.
- (3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than his/her employees, subject to limits of liability of not less than \$300,000.00 each occurrence and, when applicable \$300,000.00 annual aggregate, for non-automobile hazards and as required by law for automobile hazards.
- (4) Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than \$50,000.00 each occurrence for non-automobile hazards and as required by law for automobile hazards.
- (5) Insurance for Subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than \$300,000.00 each occurrence and when applicable, \$300,000.00 annual aggregate.

The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract (Purchase Order).

BEFORE STARTING WORK THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF PURCHASING, ORIGINAL CERTIFICATE(S) OF INSURANCE VERIFYING LIABILITY COVERAGE. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. These Certificates shall contain a provision that coverage's afforded under the policies will not be canceled until at least fifteen days prior written notice bearing the Contract Number or Purchase Order Number has been given to the Director of Purchasing.

I-T NOTICE AND RIGHT TO CURE

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature 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.

I-U CANCELLATION

The State may cancel this Contract without further liability or penalty to the State, its departments, divisions, agencies, offices, commissions, officers, agents and employees for any of the following reasons:

1. Material Breach by the Contractor. In the event that the Contractor breaches any of its material duties or obligations under the Contract, which are either not capable of or subject to being cured, or are not cured within the time period specified in the written notice of breach provided by the State, or pose a serious and imminent threat to the health and safety of any person, or the imminent loss, damage or destruction of any real or tangible personal property, the State may, having provided written notice of cancellation to the Contractor, cancel this Contract in whole or in part, for cause, as of the date specified in the notice of cancellation.

In the event that this Contract is cancelled for cause, in addition to any legal remedies otherwise available to the State by law or equity, the Contractor shall be responsible for all costs incurred by the State in canceling the Contract, including but not limited to, State administrative costs, attorneys fees and court costs, and any additional costs the State may incur to procure the services required by this Contract from other sources. All excess procurement costs and damages shall not be considered by the parties to be consequential, indirect or incidental, and shall not be excluded by any other terms otherwise included in the Contract.

In the event the State chooses to partially cancel this Contract for cause charges payable under this Contract will be equitably adjusted to reflect those services that are cancelled.

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a

cancellation for convenience, effective as of the same date, and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2. Cancellation For Convenience By the State. The State may cancel this Contract for its convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall 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 Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 30 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.
3. Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The 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 project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.
4. Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity.
5. Approval(s) Rescinded. In the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, section 5, and Civil Service Rule 4-6. Cancellation may be in whole or in part and may be immediate as of the date of the written notice to the Contractor or may be effective as of the date stated in such written notice.

I-V RIGHTS AND OBLIGATIONS UPON CANCELLATION

1. If the Contract is canceled by the State for any reason, the Contractor shall,(a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Administrator or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the

maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.

2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date. All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.
3. If any such cancellation by the State is for cause, the State shall have the right to set-off against any amounts due the Contractor, the amount of any damages for which the Contractor is liable to the State under this Contract or pursuant to law and equity.
4. Upon a good faith cancellation, the State shall have the right to assume, at its option, any and all subcontracts and agreements for services and materials provided under this Contract, and may further pursue completion of the Work Product under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

I-W EXCUSABLE FAILURE

1. Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the non-performing party will be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.
2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable

discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor. The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I-X ASSIGNMENT

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the State Purchasing Director.

I-Y DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.

I-Z NON-DISCRIMINATION CLAUSE

In the performance of any Contract or purchase order resulting herefrom, the bidder agrees not to discriminate against any employee or applicant for employment, with respect to their 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 unrelated to the individual's ability to perform the duties of the particular job or position. The bidder further agrees that every subcontract entered into for the performance of any Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2101, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.

I-AA MODIFICATION OF SERVICE

The Director of Purchasing reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks which this service shall encompass and/or any other modifications deemed necessary. Any changes in pricing

proposed by the Contractor resulting from the requested changes are subject to acceptance by the state. Changes may be increases or decreases.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

I-BB ACCEPTANCE OF PROPOSAL CONTENT

The contents of this document and the vendor's proposal will become contractual obligations. Failure of the Contractor to accept these obligations may result in cancellation of the award.

I-CC REVISIONS, CONSENTS, AND APPROVALS

This Contract may not be revised, modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

I-DD ENTIRE AGREEMENT

This Contract shall represent the entire agreement between the parties and supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

I-EE NO WAIVER OF DEFAULT

The failure of a party to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-FF SEVERABILITY

Each provision of the Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-GG 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 this Contract.

I-HH RELATIONSHIP OF THE PARTIES

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.

I-II NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, at previously agreed-upon addresses, 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 (3rd) 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.

I-JJ UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall 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 pursuant to 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, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-KK SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor's indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

I-LL GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

I-MM YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom.

I-NN CONTRACT DISTRIBUTION

The Office of Purchasing shall retain the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by the Office of Purchasing.

I-OO TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to six (6) months after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition

assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.

I-PP DISCLOSURE OF LITIGATION

1. The Contractor shall notify the State in its bid proposal, if it, or any of its subcontractors, or their officers, directors, or key personnel under this Contract, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation or deception. Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding which may have arisen or may arise involving the Contractor or any of the Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract and three years thereafter.
2. The Contractor shall notify the State in its bid proposal, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments that may have arisen against it or its subcontractors during the five years proceeding its bid proposal, or which may occur during the term of this Contract or three years thereafter, which involve (1) products or services similar to those provided to the State under this Contract and which either involve a claim in excess of \$250,000 or which otherwise may affect the viability or financial stability of the Contractor , or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor, in any an amount less than \$250,000 shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.
3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal or civil investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Semi-annually, during the term of the Contract, and thereafter for three years, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State.
4. Assurances - In the event that such investigation, litigation, arbitration or other proceedings disclosed to the State pursuant to this Section, or of which the State otherwise becomes aware, during the term of this Contract, causes the State to be reasonably concerned about:
 - a) the ability of the Contractor or its subcontractor to continue to perform this Contract in accordance with its terms and conditions, or
 - b) whether the Contractor or its subcontractor in performing services is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration or other proceedings, which conduct would constitute a breach of this Contract or violation of Michigan or Federal law, regulation or public policy, then the Contractor shall be required to provide the State all reasonable assurances requested

by the State to demonstrate that: (a) the Contractor or its subcontractors hereunder will be able to continue to perform this Contract in accordance with its terms and conditions, (b) the Contractor or its subcontractors will not engage in conduct in performing services under this Contract which is similar in nature to the conduct alleged in any such litigation, arbitration or other proceedings.

5. The Contractor's failure to fully and timely comply with the terms of this section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of this Contract.

SECTION II

WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

The State provides health benefit services through the State Health Plan (SHP – the traditional, non-HMO medical plan) to employees, retirees, and their eligible dependents. These basic health programs are currently administered by Blue Cross Blue Shield of Michigan (BCBSM), and by Aetna. For the majority* of these eligible members, mental health and substance abuse (MHSA) services are managed and provided through a preferred provider organization (PPO). These programs are self-funded on an Administrative Service Only (ASO) basis.

(*Note: this plan excludes MHSA services Troopers and Sergeants, and Troopers and Sergeants who retire or retires on or after 10/1/1987, who receive MHSA services through the SHP medical plan vendor.)

The State provides MHSA PPO services to approximately 34,000 active employees and COBRA participants, plus their 53,000 dependents, as well as 33,000 retirees, plus their 20,000 dependents, for a total covered membership (employees/retirees, plus dependents) of 140,000. The plan is self-funded by the State, and is currently administered by Value Options.

A summary of the annual claims cost and utilization data under this program is attached as Appendix C.

II-B OBJECTIVES

The objectives of this managed MHSA PPO benefit services competitive bidding are:

- provide a managed MHSA PPO program for active employees, COBRA participants, retirees, and eligible dependents;
- obtain competitive pricing and effective care management for MHSA services through a broad network of participating providers offering convenient access to employees, retirees, and their dependents;
- maintain a high level of member satisfaction with the program;
- obtain timely utilization reporting; and
- improve service with expanded customer and account service features, including performance guidelines and penalties.

The objective of this Contract is to provide and manage the administration of the managed MHSA PPO benefit program for the State.

II-C TASKS/PLAN REQUIREMENTS

The Contractor must meet the following requirements.

1. Plan Design

The vendor must be able to duplicate the current plan design (see Appendix A for more detail).

It should be noted that this plan is a bargained benefit, and is subject to change, depending on the results of future bargaining agreements (the next collective bargaining agreement will be effective October 1, 2002). Historically, non-bargained employees and retirees have received the same benefits as bargaining employees, but this is not guaranteed.

Appendices C and D contain utilization and census data. Census data is also provided in the enclosed data diskette.

2. Covered Services

Covered services are described in the benefit summaries attached as Appendix A. In general, inpatient and outpatient MHSA services are accessed through, and care managed by, the PPO providers. Providers include professional psychiatrists, psychologists, alcoholism counselors, social workers and psychiatric nurses. Facilities may include acute care hospitals, approved psychiatric facilities, day/night centers, halfway houses, and residential care facilities. Care management will include precertification of all inpatient care, discharge planning, concurrent review, and individual case management (ICM).

Limitations and Exclusions

In addition to the exclusions described in the benefit booklet and payment rules in attached Appendix A, benefits will not be paid for:

- a. Services provided or covered by any state or governmental agency, by Worker's Compensation or similar occupational law, or for which no charge is made to the employee.
- b. Services provided while the member is not covered for this benefit.
- c. Services provided that the health professional or facility is not licensed to provide.
- d. Services which are not medically necessary, or are experimental or research in nature, according to accepted standards of practice.
- e. Services received as a result of an act of war, declared or undeclared.
- f. Completion of any insurance form.
- g. Medical services, drugs or medications not administered for the purpose of MHSA treatment.

3. Administrative Services

Administrative services must include, but need not be limited to, the following:

Information Systems:

- Ability to accept up to two feeds of eligibility information, on a weekly basis, from the State, in the form of magnetic tapes, diskette, CD-ROM, a dial-up connection or the Internet. Data for active, COBRA and direct pay participants will be supplied through the Human Resource Management Network (HRM) (format attached as Appendix B). Data for retirees will be supplied in magnetic form by the SHP medical plan vendor.
- Ability to accept eligibility information, by electronic data interchange (EDI), by October 1, 2001
- Ability to administer eligibility and claims administration in accordance with the plan design.
- Confidentiality of all data by the vendor.
- Maintenance of records for auditing and management information reporting and analysis.
- Monthly, quarterly and annual reporting, on an accurate, timely basis, of plan activity and experience data to the State.

Financial Arrangements:

- Competitive contracted reimbursement rates with participating providers.
- Maintenance of schedules of maximum payment levels, based on Usual, Customary and Reasonable (UCR) or other basis, for reimbursing non-participating providers.
- A contracted fixed administrative fee per covered employee or retiree per month (the same fee for actives and retirees).
- Accept electronic fund transfers of claims costs on a weekly basis, and administrative fees on a monthly basis.

Participant Services:

- Customized participant communications (with all communications subject to the State's approval).
- Customer service activities to include but not be limited to:
 - access 24 hours per day, 7 days a week,
 - a single front-end toll-free 800 telephone number with touch-tone routing (if necessary) for member services to respond to requests for participating provider locations, referrals, authorizations for care, inquiries on claims, and complaints about provider practices and services,
 - a voice response system (if necessary) with a user-friendly menu that customers find easy to understand,
 - separate 800 numbers for participants and providers, and
 - development of same services through the Internet.
- Comprehensive patient and provider education services.

Network and Utilization Management:

- Initial credentialing, monitoring, and re-credentialing of network providers.
- Periodic on-site audits of participating providers as necessary.
- The proposal must contain statements describing the steps that the vendor will take to ensure accuracy, quality control, timeliness, and benefit cost effectiveness.
- The quality assurance component of the program must contain, at the minimum, the following elements:
 - Measures such as readmission rates, number of professionals per episode of care, interventions by the Benefits office, network utilization, and member satisfaction,
 - Illness severity protocols for inpatient and outpatient treatment and day treatment plans,
 - Peer review procedures, both concurrent and retrospective,
 - Patient/provider satisfaction surveys,
 - A methodology for conducting outcome analysis within the confines of confidentiality for both inpatient and outpatient care, and
 - Criteria to evaluate provider performance, such as waiting times for routine and emergency care appointments, patient load, and arrangements for non-emergency or urgent care.

Account Management:

- An assigned account representative, and assigned service representatives, responsive to inquiries, requests and issues raised by the State.
- A psychiatrist and a psychologist available to provide analytical assistance and clinical advice to the State.

4. Subcontracting

Provisions regarding use of subcontractors are given in Section I-D. The State expects that all essential services associated with delivery of this program will be provided directly by the vendor, and that use of subcontractors will be minimal, with the possible exception of certain peripheral services such as printing, communications design, etc.

5. Funding

The State wishes to fund the managed MHSA PPO program on an administrative services only (ASO) basis, for the duration of the contract.

6. Eligibility

Eligibility will be transferred via tape, diskette, CD-ROM, EDI, Email or the Internet no less frequently than on a bi-weekly basis. There may be separate data feeds for active employees, COBRA participants, direct pays, and retirees. The bidder must have the capabilities to accept electronic data transfer, and to administer membership information in compliance with HIPAA requirements. The data format

for active employees, COBRA and direct-pay participants is attached under Appendix B.

7. Performance Guarantees

The conditions and penalties of this Section must be agreed to as presented below.

The State will require the successful bidder to contractually agree to Performance Standards. The objective of these standards is to encourage an acceptable level of performance in key contract administration areas. These include:

- Eligibility,
- Claim turnaround time,
- Claim payment accuracy on both a dollar and per occurrence basis,
- Member satisfaction, and
- Inquiry handling.

a. Eligibility

The Contractor will update (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) eligibility files with the State eligibility input within 2 business days of receipt.

At least 85% of the identification cards will be created and distributed through the U.S. Mail within 10 business days of receipt of the State eligibility tapes, and 100% within 15 business days, with an accuracy rate of 99% or better for the ID cards.

The Contractor will issue additional identification cards within 10 business days of request from enrolled members.

b. Claim Turnaround Time

1. The maximum time period between date of receipt by the Contractor and the date of payment (or denial) is expected to be no greater than 10 business days for 85% of all claims, and 20 business days for 99%. Requests for additional data from either the beneficiary or the provider shall be within the same standards.

2. The Contractor must ensure that the performance guarantees are measurable using the vendor's standard systems in place.

c. Claims Accuracy

The State shall audit the Contractor's administration of MHSA claims for accuracy. The State's approach has been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. This approach may change without prior notice.

The Contractor will not be liable for errors caused by the State, nor will the State be liable for errors caused by the Contractor. The errors will be established by using statistically significant sampling methods resulting in a 95% confidence level with precision of +/- 3%. The State will include adjustments made up to four months after the close of the audited year. If claims samples are selected using a financially stratified methodology, the results will be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.

Financial Payment Accuracy: measures the dollar value of errors. Calculated as total audited paid dollars minus the absolute value of over- and underpayments, divided by total audited paid dollars. The acceptable error rate for the first year of the contract will be 1% (i.e., a 99% accuracy rate), and 0.7% for subsequent contract years (99.3% accuracy rate).

If the error value for a review period exceeds the acceptable error value and the difference is statistically significant, the Contractor will be liable up to the midpoint of difference between the acceptable error value and the statistically determined value. The acceptable error value is the acceptable error rate multiplied by net paid claims during the review period. The standards, incentives, and penalties shall be as shown below:

FINANCIAL PAYMENT ACCURACY

Review Period	Error Standard as a % of Dollars Paid	Penalty Charged for Each Error Above Standard
Year One	1.0% of net claims	Amount above standard
Year Two	0.7% of net claims	Amount above standard
Year Three and Thereafter	0.7% of net claims	Amount above standard

Payment Incidence Accuracy: Measures the incidence of claims processed without payment error. It is defined as the percentage of audited claims process without payment error. The definition of error includes any type of error (e.g., coding, procedural, system, payment, etc.) that results in a payment error. It is calculated as the total number of audited claims minus the number of claims processed with “payment” errors, divided by the total number of audited claims. The acceptable error rate for the first year of the contract will be 3% (97% accuracy rate), and 2.5% (97.5% accuracy rate) for subsequent contract years.

Claims Processing Accuracy: Measures the overall claims processing accuracy, based on whether or not the claims was processed without an error. Claims processing accuracy is calculated as the total number of audited claims minus the number of claims with errors, divided by the total number of audited claims. The acceptable error rate for the first year of the contract will be 5% (95% accuracy rate), and 4% (96% accuracy rate) for subsequent contract years.

At least 10% of annual administrative fees will be at risk if all of these standards are not met.

d. Inquiry Handling

95% of written inquiries that the Contractor receives either from the Employee Benefits Division or members will be answered within 5 business days, and 100% within 10 business days. The response time is calculated from the date of receipt by the Contractor to final resolution.

100% of phone inquiries will be returned within 24 hours.

The inquiry telephone line for members will have no more than 5% lost calls.

The inquiry telephone system must maintain sufficient staffing to respond to telephone calls by not allowing in excess of 30 seconds on hold for more than 90% of the calls received.

At least 85% of participants must be satisfied with the contractor's customer service.

At least 10% of administrative fees are at risk if these standards are not met.

8. Systems and Reporting Requirements

a. Claim Information

Maintenance of detailed claims information is necessary to facilitate claims review and cost containment functions. It is also essential to produce reports to be submitted to the State for use in effectively administering the program.

Data collected on behalf of the State program is not to be distributed to any party without the written consent of the State and is not to be used by the Contractor for any purposes unless specifically approved by the State. All data identifying specific enrollees or their dependents are highly confidential and are to be treated accordingly.

Appendix E contains a list of data elements that must be maintained by the Contractor to meet the State's claims review and reporting requirements. While the list reflects current needs, capture of additional claim items may be required by the State. It will be the responsibility of the Contractor to maintain records in such a manner that will allow reporting of claims submitted by providers.

b. Claims Records Tape File

To provide the State with an in-house capacity to conduct detailed analysis of activities related to MHSA, the Contractor will be required to provide, on a regularly scheduled basis, a suitable tape or disk file containing detailed claim records in a format required by a contractual claims analysis company.

The file is to be produced quarterly, and submitted to the data consolidation vendor specified by OSE. The detailed data elements covering the production of the claims file are contained in Appendix E.

c. Contractor/State Interface

The following are additional Contractor requirements related to the necessary systems interface between the selected Contractor and the State.

1. Capability to accept the State's computerized enrollment files (see Appendix B) and process change transactions to maintain up-to-date information for claims certification.
2. A dedicated staff of systems professionals to provide timely service covering systems analysis and programming required to implement system changes and produce reports.
3. Designation of a high-level management staff member to serve as liaison for systems related matters.
4. Full on-line eligibility access for OSE staff with both inquiry and update capabilities.
5. Ability to interface directly with the State's personnel information system, through a secure access method implemented with the State.

d. Reports.

The State expects to receive the Contractor's standard report package and those reports described below. Failure to adhere to the timeframes indicated will result in penalties.

- Monthly reports, including:
 - A brief summary (in letter form) of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months,
 - Claims Report, showing claims paid in the month, split between Actives, COBRA and Retirees, showing number of admissions, days/visits/services, charges, employee copays, and plan payments, split by network and non-network, by categories of inpatient and outpatient services,
 - Claims "lag" report, accumulated year-to-date in the format shown in Appendix F,
 - Number of subscribers and number of dependents covered, split between Actives, COBRA and Retirees,
 - Produced within 30 calendar days of the end of the month,
 - At least 5% of the monthly administrative fees are at risk if this report is not available within the timeframe stated.

- Quarterly reports, including:
 - Quarterly and YTD summaries of Monthly Claims Report.
 - Utilization review and case management summaries, which provide the following items:
 - ... response time (in days) to practitioner's request for authorization of admission and continued care,
 - ... time (in days) from admission or referrals to day reviewed,
 - ... admits per thousand and ALOS for adults and adolescents for claims under case management,
 - ... number of reconsideration claims submitted and length of time (in days) to make reconsideration,
 - ... reversal rate for medical necessity decisions for both internal reconsideration and external appeals,
 - ... case management information, including the number and cost of case management activities, referencing the type of provider utilized, focus of task, and amount of savings achieved, and
 - ... number and % of total cases in case management that resulted in alternative treatments.
 - Network management report, including the following items:
 - ... number of providers identified as requiring further investigation,
 - ... number of providers for which more details were requested and are currently pending, with number concluded with no adverse recommendations,
 - ... percent of providers reviewed in monitoring patterns of abuse,
 - ... average time from identification of the problem to conclusion of the investigation,
 - ... number of complaints made and number unresolved,
 - ... summary of all reconsiderations and appeals, and
 - ... number of providers and ratio of providers to claims.
 - Detailed claims file, in the format described in Appendix E, provided to the State's specified data vendor,
 - Produced within 60 calendar days of the end of the quarter,
 - At least 5% of the quarterly administrative fees are at risk if this report is not available within the timeframe stated.

- Annual Report (results through September 30th), including:
 - Management summary,
 - Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis,
 - Claims coordinated, split by claims coordinated with the State-sponsored health plans, and by spouse's employer-sponsored medical and/or MHPA plans,
 - Produced within 90 calendar days of the end of the year,
 - At least 5% of the annual administrative fees are at risk if this report is not available within the timeframe stated.

The State is also *very* interested in on-line or electronic reporting capabilities. A description of capabilities will be requested as part of the RFP response, and will be included in the evaluation of the proposal.

9. Network Match

The bidder must propose a national network of preferred providers in areas where State employees and retirees reside. A diskette containing counts by zip codes for all eligible employees and retirees is enclosed.

General standards are at least one professional (psychiatrist or psychologist) participating provider within 5 miles in urban areas, 10 miles in suburban areas and 20 miles in rural areas, and one facility (acute care hospital and residential care facility) within 10 miles in urban areas, 20 miles in suburban areas, and 40 miles in rural areas (see Section IV-D, 5). GeoAccess reports should be run separately for active employees and retirees.

10. Identification Cards

Identification cards must be provided to eligible employees, retirees and their dependents.

11. Communication Materials

Bidders will prepare and cover the cost of all announcements, letters, notices, brochures, forms, postage and other supplies and services for U.S. mail distribution to employee and retiree residences.

The State will have approval of drafts of communication materials. All information/material must be approved by the State prior to use.

12. Audits

It is the State's intention to periodically (no less often than once every three years) perform on-site audits of plan administrators. Vendors will make records associated with the administration of the State plan available to, and must cooperate with, such auditors and audits as the State may designate. The State's current approach has been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. For example, for plan years October 1, 2000 through September 30, 2002, the State would request an audit of MHSA claims to be completed by September 30, 2003. This approach may change without prior notice.

II-D PROJECT CONTROL AND REPORTS

I. Project Control

- a. The Contractor will provide these services under the direction and control of the Office of the State Employer.
- b. Although there will be continuous liaison with the Contractor team, the contract director will meet quarterly during the first contract year as a minimum, with the Contractor's project manager for the purpose of reviewing progress and providing necessary guidance to the Contractor in solving problems which arise.

- c. The Contractor will submit, as part of the monthly report (see II-C 8.d.) brief written summaries of significant activities during the month, issues or problems, real or anticipated, which should be brought to the attention of the client agency's project director, and significant activities anticipated for subsequent months.
- d. Within five (5) working days of the award of the Contract, the Contractor will submit to the Contract Administrator, for final approval, an implementation plan. This final implementation plan must be in agreement with Section IV-C subsection 2 as proposed by the bidder and accepted by the State for Contract, and must include the following:
 - (1) The Contractor's project organizational structure.
 - (2) The Contractor's staffing table with names and titles of personnel assigned to the State's account, and expected percentage of their time dedicated to this contract. This must be in agreement with staffing of accepted proposal. Necessary substitutions due to change of employment status and other unforeseen circumstances may only be made with prior approval of the State.
 - (3) The project breakdown showing sub-projects, activities and tasks, and resources required and allocated to each.
 - (4) The time-phased plan in the form of a graphic display, showing each event, task, and decision point in your implementation plan.

II-E PRICE PROPOSAL

All rates quoted will be firm for the duration of the Contract. No price changes will be permitted.

II-F CONTRACT PAYMENT SCHEDULE

The specific payment schedule for this Contract will be mutually agreed upon by the State and the Contractor(s). The schedule should show payment amount and should reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy statements shall be forwarded to the designated representative by the 15th day of the following month.

Contractor must have the capability to accept electronic fund transfers weekly for claims costs, and monthly for administrative expenses.

APPENDIX A

BENEFIT BOOKLET AND PAYMENT RULES – CURRENT PLAN

APPENDIX B

ENROLLEE/DEPENDENT DATA FORMAT (INCLUDING ZIP CODES),(HRMN)

APPENDIX C
BEHAVIORAL HEALTH COST/UTILIZATION DATA

APPENDIX D
CENSUS DATA

APPENDIX E
DATA ELEMENTS

APPENDIX F
SAMPLE CLAIMS LAG REPORT

IV-A BUSINESS ORGANIZATION

State the full name and address of your organization and, if applicable, the branch office or other subordinate element that will perform, or assist in performing, the work hereunder. Indicate whether it operates as an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated. If appropriate, state whether it is licensed to operate in the State of Michigan.

As an-attachment, include your most recent financial statement.

Magellan Behavioral of Michigan, Inc. (MBM), a corporation licensed to operate in the State of Michigan, is headquartered at 34705 W. 12 Mile Road, Suite 148 in Farmington Hills, Michigan. MBM provides regional managed behavioral health operations and was established in 1994 by Green Spring Health Services (GSHS). MBM currently provides managed behavioral health services and EAP services to over 2.7 million Michigan citizens. MBM employs an experienced clinical and administrative staff of 70 employees represented by United Auto Workers (UAW). MBM comprehensive operations include:

- Care management services
- Bi-monthly Provider Advisory Group meetings
- Semi-annual provider forum meetings
- Monthly Labor Advisory Group meetings
- NCQA-driven Quality Improvement Program
- Dedicated account management

MBM is the Regional Service Center (RSC) for Magellan Health Services, the successor to Green Spring Health Services. The corporate headquarters are located in Columbia, Maryland.

We have included a copy of our most recent financial statement in Appendix A.

IV-C MANAGEMENT SUMMARY**1. Narrative**

Include a narrative summary description of the proposed effort and of the product(s) that will be delivered. If any support is to be provided by a subcontractor, said subcontractors are to indicate their capability and willingness to carry out the work. In addition, the information requested in IV-A above, and IV-D below, should be provided for each potential subcontractor.

Following is an overview of Magellan's proposed management effort by specific goal and product strategy. We do not intend to utilize any subcontractors for our administrative services.

Project Administration

Magellan's goal is to achieve highly effective account management for contract implementation and for monitoring and management of mental health/substance abuse benefits services delivered to the State's membership.

In order to achieve this goal we will convene the Magellan/State of Michigan implementation team and tightly manage a prompt and efficient implementation. On an ongoing basis, we will provide extensive, reliable 24 hour, 7 days a week account management support. Our approach will be proactive; anticipating issues or State needs and developing immediate solutions.

Member Communications

The goal is to maximize member education to:

- Ensure member friendly plan utilization
- Familiarize members with the MH/SA program to ensure ongoing ease of access
- Distribute in a timely manner membership cards and member information

In order to meet this goal, we will work with the Division to present and refine our comprehensive communications strategy to include a communications package.

Our Member Communications Package will include:

- Insert for State's benefits brochure including summary of plan, questions, and answers, covered services, member rights and obligations
- Provider directory on paper and through the Internet to include name, professional category and license, specialty, office address and telephone number
- Articles to be included in any of the State's employee newsletters

- Information for the State's website and a linkage to Magellan's dedicated State of Michigan website
- Availability for presentations at enrollment fairs
- Worksite educational programs on issues such as stress, violence, family problems

Member Services

Our goal is to ensure access and maintain responsive service in regard to furnishing information and responding to questions and concerns.

Our strategy to achieve this goal will include:

- Recruitment of seasoned customer service representatives to be dedicated to the State account
- Continually training and monitoring telephone access, customer service skills and responsiveness
- Administering a State specific member satisfaction survey and monitoring results to ensure service consistency
- Continually tracking and promptly responding to complaints and grievances

ESD Coordination

Our goal is to work with the Employee Services Division to ensure a high level of coordination.

Our strategy to achieve this goal will include:

- Meet with ESD to determine any priorities, procedures for coordination
- Ongoing communication
- Technical support upon request

Utilization Review/Care Management Policies and Procedures

Our goal is to ensure that our program continually meets the State's preferences for clinical operations.

To achieve this goal, we will:

- Review our policies and procedures with the State
- Continually monitor utilization review and care management processes for compliance with these policies and procedures

- Refine policies and procedures per the State's requirements and preferences

Quality Improvement

Our goal is to meet the State's goals for a mental health/substance abuse benefits quality improvement program.

Our strategy to achieve this goals will include:

- Review with the State and modify, as appropriate, Magellan Quality Improvement activities and structure
- Solicit employee benefits division participation in QI activities
- Present QI findings to the State
- Use QI data to revise programs, as appropriate

Eligibility/MIS Management

Our goal is to incorporate State of Michigan eligibility formats and files into Magellan's management information systems to ensure seamless transfer.

To achieve this goal, we will:

- Identify and define any steps required to transfer member eligibility information
- Develop and implement any additional mapping specifications for data interface
- Continually monitor eligibility transfer

Claims Systems

Our goal is to assure that Magellan's claims payment systems meet all performance standards established by the State of Michigan.

Our strategy to meet this goal will include:

- Developing with State approval, any revised claims submission/rejection procedures to comply with State requests
- Ongoing monitoring of timeliness and accuracy of claims payment in accordance with State performance standards

Reporting

Our goal is to provide reports which meet the State's information needs promptly and comprehensively.

In order to meet this goal, we will:

- Modify report structures to develop custom reports as requested
- Gain employee benefit division approval of sample reports
- Continue to produce state-of-art monthly, quarterly and yearly reports

Network Development

Our two goals are to:

- Maintain a MH/SA provider network that provides superior access, choice, and service to meet the needs of State of Michigan members
- Monitor our network to ensure that members receive high quality services and work collegially with the provider community to ensure provider participation

Our strategy to obtain these goals includes:

- Review with the State any desired network enhancements related to specialty, choice, or geography
- Build out the network, as requested
- Continue to monitor network access standards
- Credential and recredential the network according to NCQA/CVO or any State specific credentialing standards
- Maintain provider relations activities such as education and communications

IV-C MANAGEMENT SUMMARY**4. Key Personnel/Account Management**

Supply names, resumes' (including education, experience, and other assigned groups), and expected portion of time assigned to the State account, for the following Key Personnel to be assigned to the State account:

- The Account Manager,
- The Service Manager, and
- The Clinical Director

To ensure the efficient administration of the State account, there will be a dedicated account management team assigned to the State. Anticipating the unique needs of your account, Jim Kinville, President of MBM will be your account manager. He will work closely with Gary Reidenbaugh, the Service Manager and Evelyn Thomas, Clinical Director. Mr. Reidenbaugh will be devoted to the account full time. Mr. Kinville and Ms. Thomas will devote at least 40 percent of their time to the State during implementation and a minimum of 20 percent of their time to the State account on an ongoing basis. Copies of their resumes are included in Appendix B.

IV-C MANAGEMENT SUMMARY**5. Subcontractors**

It is the State's expectation that all essential services associated with delivery of this program will be provided directly by the vendor, with the possible exception of certain peripheral services, such as printing, communications design, etc. List here all subcontractors; include firm name and address, contact person, complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization and abilities.

Magellan will perform all services referenced in this response. There are no subcontractors.

IV-D QUESTIONNAIRE

1. Company Overview

- A. Provide a brief history of your organization. Describe the number of years your organization has been in business, the number of years it has been providing MHSA benefit services, and the number of covered members in each of the past three years.

Magellan Behavioral Health, Inc. is a subsidiary of and 100 percent owned by Magellan Health Services, Inc. Magellan Health Services created Magellan Behavioral Health in 1998 by consolidating three behavioral healthcare companies: Green Spring Health Services (GSHS), Human Affairs International (HAI), and Merit Behavioral Care (MBC). The combined companies of Magellan have been providing behavioral healthcare services (MH/SA) since 1973.

Magellan Behavioral of Michigan, Inc. (MBM), headquartered in Farmington Hills, MI, provides regional operations and was established in 1994 by GSHS. MBM currently provides managed behavioral health services and EAP services to over 2.7 million lives. Magellan Behavioral of Michigan employs an experienced clinical and administrative staff of 70 employees represented by United AutoWorkers (UAW).

MBM has served the following numbers of covered members in the past three years:

- 1997 - 2.5 Million lives
- 1998 - 2.6 Million lives
- 1999 - 2.6 Million lives

Magellan Behavioral Health has served the following number of covered lives in the past three years.

- 1997 - 20 million lives*
- 1998 - 62 million lives
- 1999 - 68 million lives

*Magellan was not formed until 1998; therefore, this represents the number of lives covered by Green Spring Health Services, the preceptor of Magellan.

Magellan Behavioral Health currently serves over 70 million lives.

- B. Have you recently been involved in any mergers and acquisitions (M&As) in the last 3 years? Are there any M&As or dispositions planned in the next 12-24 months?

MBM has not been involved in any mergers or acquisitions in the last 3 years. There are none planned within the next 12-24 months.

- C. Describe your company's MHSa care philosophy, and approaches to provider contracting, administration, quality control and customer service.

Magellan's Managed Care Philosophy

A major tenet of Magellan's treatment philosophy is to provide the proper amount and intensity of care in the most appropriate setting in the manner least intrusive to the patient. At Magellan, we advocate focused, goal-oriented treatment that is both clinically effective and cost efficient. Our goal is to treat the patient to the point where he or she can return to a normal functioning lifestyle in the community and achieve long-term stability. The quality outcomes generated by this philosophy in turn enhance program effectiveness. We have consistently achieved these results for the accounts which we serve by adhering to the key principals described below.

Promote Early And Unrestricted Access To Medically Necessary Care

We have found consistently through our experience in delivering MH/SA services that open access to care and reduced overall costs of providing that care go hand in hand. Typically, the earlier the intervention, the less costly the care required, and the less likelihood of the need for a return to treatment. Magellan makes an assertive effort to eliminate any barriers that will inhibit ease of access into our MH/SA system.

Support Active Use Of A Full Continuum Of Care

Ensuring appropriate utilization of services along the care continuum is a pivotal means by which Magellan maximizes the quality and effectiveness of the behavioral healthcare delivery system. The efficacy of using the full continuum of care is supported by numerous clinical studies throughout the past 19 years, demonstrating that intermediate-level settings are equally as or more clinically effective than traditional inpatient settings.

Commitment to Outcomes Based Research and Treatment Protocols

A key indicator of any high-quality managed MH/SA program must be a demonstration of improved clinical outcomes. We have in place an extensive series of indicators of successful outcomes—both clinical and non-clinical. For example, we regularly monitor patients' GAF scores (which report level of functioning), track relapse and recidivism rates on our internal patient care tracking system, and administer patient satisfaction surveys to determine the degree to which members feel they have been helped through treatment. We also do targeted clinical outcome studies through our Quality Improvement Service Bureau to study and implement ways in which we can improve overall clinical effectiveness.

Use Targeted Intensive Management to Improve Outcomes and Reduce Recidivism

Fundamental to our approach to managing MH/SA services is the effective and efficient targeting of clinical management resources. We carefully review and monitor every inpatient case, so that patients can be safely and effectively transitioned to increasingly less restrictive treatment settings as they improve. We also use clinical screens and quality assurance checks to identify those outpatient cases that require frequent or intensive case management. Lastly, to ensure consistently effective and targeted treatment planning, we also bring to bear the expertise of a local and national panel of clinical experts who can provide specific consultation on clinical issues such as substance abuse, child psychiatry, eating disorders, post-traumatic stress disorder and other special diagnostic situations.

Approach To Provider Relations**Select and Maintain the Highest Quality Provider Network**

We believe that the most important single contributor to effective, high quality treatment is the quality and capability of the provider network itself. By selecting and supporting providers who rely on targeted, goal-oriented therapeutic interventions, Magellan is able to foster improved treatment outcomes by ensuring that patients are treated by providers well qualified to assist them in any given situation. It is for this reason that we devote so much of our operational and clinical resources to network development, education, and ongoing provider profiling and network enhancement activities.

Promote Collegial Provider Relations Through Clinical Collaboration

In many cases, friction exists between managed care organizations and providers. Providers perceive that they receive arbitrary assessment of medical necessity, one driven by benefit management. Moreover, they are forced to spend excessive time in the authorization process.

Magellan supports a very different approach in working with the provider community. Our care management process is collegial in spirit and focused on ensuring the best disposition of the patient in the most effective manner. In order to ensure that we work in concert with providers to achieve access and quality care, we have simplified our authorization and treatment review process for routine outpatient care. Our focus on case management of complex and intensive need cases allows our care managers to devote their time to the cases with the greatest needs and to assist providers in complex treatment coordination.

Approach to Administration**Flexibility and local commitment**

Magellan's regional service center model allows us to administer programs and provide service where the members reside so they can tailor our systems, network and processes to local need. The flexibility of our administrative operations is reflective of our philosophy that the effectiveness of service is dependent on it's relevancy for a given area or account.

Approach to Quality Improvement

Magellan believes quality is defined by the State's, the members', and the providers' expectations, as well as by accepted professional standards of practice. We integrate quality improvement (QI) initiatives into every area of functioning.

Magellan has made a total organizational commitment to incorporate quality standards into our delivery of care and service. Our efforts have led to continually improved services for members, and documented accountability to payors, employer groups and the public. Magellan has been proactive in seeking NCQA managed behavioral health organization (MBHO) accreditation. MBM received a NCQA one year MBHO Accreditation on July 19, 2000.

As a further testament of their commitment to quality, MBM is currently accredited by the American Accreditation Healthcare Commission (AAHCC, formerly URAC) through 2001.

Approach to Customer Service

Magellan believes that customer service permeates all of our operations. It begins with effective member communications and continues with telephone and computer access, timeliness and convenience of network service, as well as claims payments and other administrative processes. We recruit well qualified staff for customer relations activities, and we devote considerable time and effort to training and monitoring their performance. Compliance with our stringent customer service standards is continually assessed and closely analyzed for possible enhancement in our systems and workflows.

- D. Describe any features of your organization that distinguish it from your competitors, and why the State should consider selecting your organization over other MHSA care vendors.

Magellan's key differentiators, and examples of why the State should consider selecting Magellan over other MHSA care vendors are described below:

- **Local commitment.** Our Magellan staff, headed by Jim Kinville, the MBM President are well respected and well known in the managed behavioral health arena in Michigan. Jim Kinville, who will be the State's account manager, as well as the key staff that would work with the State have extensive experience with the State membership as well as the providers who serve this population. Mr. Kinville has headed MBM since 1996 and previously worked with the State's current vendor. Gary Reidenbaugh, the proposed service manager, currently is the account manager for MESSA and previously was the account manager for the State's current vendor. Evelyn Thomas, the proposed clinical director, has over 15 years of clinical experience in Michigan including clinical leadership with the State's current vendor.
- **Flexibility.** Magellan is committed to meeting the State's program/structure to meet its unique needs. Although we adhere to strong clinical and customer service standards, we are highly flexible in providing systems and services that are requested by an account which we serve. One of our greatest assets in working with both State and Union accounts has been our willingness and ability to meet their needs.

- **Strong Customer Service.** Magellan's focus on customer service is operationalized in our emphasis on account management, member services and provider relations. In Michigan, we have consistently exceeded over 95 percent in annual member surveys. In 1999, we surveyed our accounts to assess our account management capabilities and received consistent positive comments.
- **Commitment to Quality.** This is evidenced in the fact that Magellan has NCQA MBHO and AAHC accreditation and is the first MBHO to receive NCQA accreditation in Michigan.
- **Smooth Transition for Members and Providers.** A local implementation team of seasoned managed care professionals can ensure that our processes are efficiently and effectively operating to meet the States goals and objectives. To support a smooth transition for members and providers, we also draw upon our extensive corporate resources who support the Michigan service center in areas of credentialing, information systems and member communications.
- **Commitment to Technology.** Magellan believes that behavioral healthcare can be greatly enhanced through emerging technology. The State membership will have access to a customized website for consumer and program information; thereby maximizing access and facilitating member awareness. Provider access to our website will minimize time spent on authorization, treatment planning, and claims submission and will increase communications regarding Magellan's policies, procedures and clinical guidelines. Moreover, State to Magellan linkages will simplify administrative coordination and program monitoring.

IV-D QUESTIONNAIRE**2. Customer Service**

- A. Describe the organization's structure and provide a flow chart for the unit which answers incoming phone calls. Include any variations which may occur after hours.

Organizational Structure

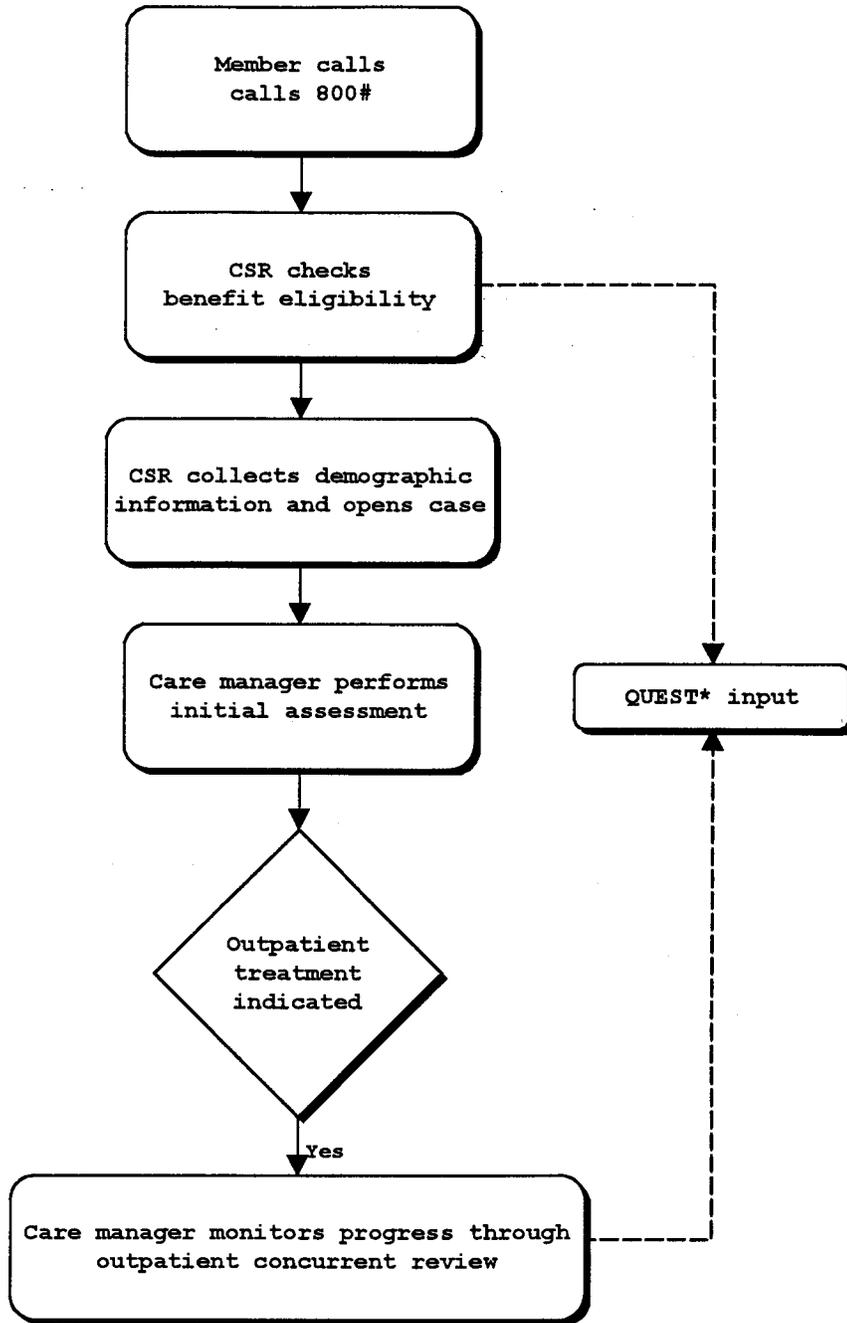
The States' members and providers will access their mental health and substance abuse benefits by dialing into the Customer Service Department located in Farmington Hills, Michigan. There will be one 800 number for members and another 800 number for providers. Customer Service Representatives (CSRs) are the first point of contact for the State's members and providers who access the **24-hour, 7 day a week, toll-free help line**. The CSRs follow the same processes on a 24-hour basis.

- Provide information regarding customer eligibility, benefits, and claims
- Recognize and direct crisis telephone calls directly to a masters or doctoral level clinician
- Provide general information on Magellan's programs, policies, and procedures
- Refer members to the care management team for a provider referral
- Provide non-clinical information on authorization status
- Collect and enter member intake information into the management information system to initiate member entry into the care management system
- Collect and document member complaint information and forward to the appropriate supervisor
- Provide information regarding reimbursement rates
- Educate providers to submit claims and when to submit member treatment plans

Many of the functions described above also are available on a real-time basis to members and providers through the Internet.

The Vice President (VP) of Clinical Operations, Evelyn C. Thomas, MSW, CEAP, supervises the Customer Service unit. She is responsible for this area as well as clinical care management services. She has over fifteen years of clinical and management experience in mental health and substance abuse services throughout the state of Michigan. She received her Bachelors in Social Work and Masters in Social Work from Wayne State University.

Figures IV-D.2-1 and IV-D.2-2 present flowcharts of the Magellan customer service unit that will be handling the outpatient and inpatient services for the States' members is included on the following pages.



*QUEST is Magellan's next-generation on-line clinical information system.

Figure IV-D.2.-1: Outpatient Access and Treatment Preauthorization



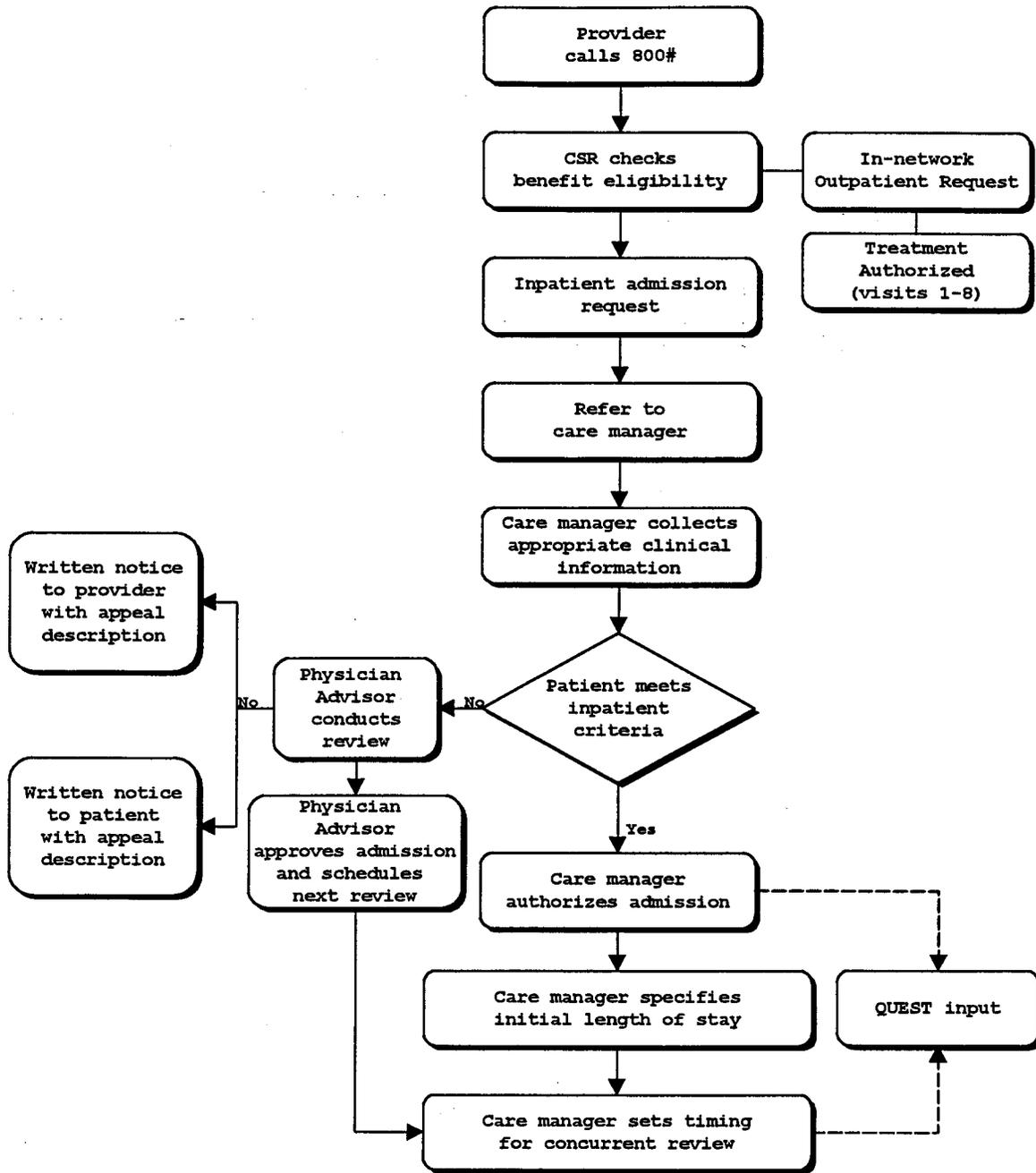


Figure IV-D.2-2: Inpatient Access and Preadmission Authorization

- B. Describe your hours of operation, including times available:
- a) Member inquiries - "live" customer service representatives
 - b) Member inquiries - voice messages
 - c) Member inquiries - emergencies
 - d) Account administration - assigned client/service managers
 - e) Provider inquiries.

Hours of Operation

a. Member Inquiries—"live" customer service representatives

Magellan's MBM Customer Service Unit is available with "live" CSRs for member and provider inquiries, Monday through Friday from 8:00 a.m. to 5:00 p.m. After 5:00 p.m. and on weekends and holidays, callers are routed to a CSR at Magellan's 24-hour on-call site in Cincinnati, Ohio. Since Magellan's services are available 24 hours a day, 7 days a week, callers can always reach a "live" person.

b. Member Inquiries—Voice messages

All of our staff have voice mail; however, this is used only when a member or provider has been given a direct number for a call-back such as to provide additional information. Voice mail is never used for initial inquiries or requests for authorization.

c. Member Inquiries—emergencies

We utilize a touch tone system in which the caller is immediately instructed to push a certain number in case of emergency.

d. Account Administration—Assigned client/service managers

Our Account Administration staff is available during normal business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. and by pager on a 24-hour basis.

e. Provider Inquiries

CSRs are available to handle provider calls for authorization on a 24 hours a day, 7 days a week basis. Providers may access CSRs for questions regarding claims Monday through Friday from 8:00 a.m. to 5:00 p.m. These functions also are available through the Internet.

- C. Confirm that the State will have the following:
- a) dedicated 800 number
 - b) dedicated CSR unit
 - c) psychiatrist/psychologist resources available for consultation.

a. Dedicated 800 Number

Yes, Magellan will provide the State two dedicated 800 numbers, one for members and one for providers.

b. Dedicated CSR Unit

Magellan will provide a dedicated CSR unit for the State.

c. Psychiatrist/Psychologist Resources Available for Consultation

Magellan will also provide the State with psychiatric and psychologist resources to be used for consultation services. Our medical director and our Michigan physician advisors are available on a full-time basis to provide care management and provider consultation.

- D. Do you currently provide automated interactive telephone communication service? Describe the menu available to callers and indicate if a touch-tone phone is required or if a voice-response feature is available. If available for our review, please provide the phone number, and sample id/login.

Automated Telephone Service

Yes, Magellan currently provides automated interactive telephone communication service to our clients. Magellan currently uses the Lucent ProLogix, which accommodates 1,600 lines and 400 trunks. This includes incoming 800 services and outgoing SDN circuits with a 16-bit Intel 80286 microprocessor, as well as the following features:

- **Call Vectoring:** Customizes handling of calls
- **Call Prompting:** Customizes announcements and helps callers reach the correct party
- **Multiple Split Queuing:** Queues call in three simultaneous splits to enhance prompt answer
- **Event Tracking:** Allows calls to be monitored for quality and performance evaluations by supervisors and quality improvement managers
- **Time of Day Routing:** Switches intake by time of day
- **Maintenance Systems:** Detects and reports early problem conditions, minimizing the possibility of failure.

The system allows terminals to connect to any number of devices, allowing greater systems integration. This allows a single line (800) analog system to be bridged into one multifunction station set, thus enhancing call coverage capabilities. The system allows automatic number selection, so that cases can be identified in an emergency and lost calls can be returned immediately by Magellan staff. The system is located both in the Magellan Behavioral of Michigan office and in the On-Call Unit in Cincinnati. The feature of time-of-day routing allows high flexibility in our call coverage capabilities. Routing of calls allows 800-line calls to be directed to on-site staff in Michigan from 8:00 a.m. to 5:00 p.m. weekdays; and to personnel in Cincinnati from 5:00 p.m. to 8:30 a.m. weekdays, and from 5:00 p.m. Friday until 8:30 a.m. Monday.

Automated Telephone Service Menu

Magellan Behavioral of Michigan's automated attendant message offers callers a very limited number of options, including immediate triage to a clinician for emergencies. During implementation of this account, Magellan's implementation team would be happy to discuss a menu that would be suitable to the State's needs. A sample toll-free number and automated script used by one of MBM's clients is stated below.

- Call into 800.382.8115
- If you are a member and need emergency care, please press 1 now.
- If you would like to leave a message for a return call, please press 3 now.

Sample ID and Telephone Log-In

Many of the functions provided by the CSR are also available on Magellan's Internet site. For the State of Michigan, we will establish a dedicated website. Members can access information on benefits, names of providers, and on general mental health issues through our website. A sample of an existing website that would be customized for the State is www.magellancare.com. After logging onto the website, and select the member option and enter the access number: 800.836.1600.

Providers can access our website for eligibility and benefits information, claims inquiry, claims submission, provider data change form and copies of treatment forms, medical necessity criteria, clinical practice guidelines, provider handbooks, and updates.

- E. Provide information about your customer service representatives and address the following points:
- a) education requirement
 - b) experience requirement
 - c) initial training program
 - d) on-going education.

a. & b. Education Requirements, Experience Requirements

Customer Service Representatives

Figure VI-D.2-3 describes education and experience requirements of our CSRs.

Figure VI-D.2-3: Customer Services Representative's Education and Experience Requirements

Position	Education and Experience
Senior CSR	<ul style="list-style-type: none"> • Meets qualifications for CSR I and II. • At least five years of customer service experience and three years within a Magellan regional service center. • Must have well-developed organizational and problem-solving skills, knowledge of telephone systems and monitoring techniques. • Demonstrated experience in providing direction to/facilitating team activities.
CSR II	<ul style="list-style-type: none"> • Demonstration of more extensive health care and/or customer service background than the CSR I. • Minimum of two years of excellent performance in a Magellan regional service center. • Demonstrated strong interpersonal and communication skills, problem-solving abilities, and mature judgment.
CSR I	<ul style="list-style-type: none"> • At a minimum, CSRs have college degrees or commensurate experience in fields relevant to their work (i.e., insurance customer service, mental health, and chemical dependency). • Extensive experience in customer service, in either the health care or insurance industries, dealing with a high call volume. • Demonstrate excellent verbal and written communication skills, a strong customer service orientation, and organizational and problem-solving skills.

The dedicated CSR unit for the State of Michigan will consist of a Senior CSR and CSR IIs. We will only use staff with more extensive experience for this account.



c. Initial Training Requirement

Each component of the training program is designed to measure and monitor the quality and scope of service provided to our clients, acknowledge and improve customer service representative performance, and maintain a focus on continuous quality management and customer satisfaction. CSRs undergo an intensive orientation and training program upon the commencement of their employment with Magellan. The training program is 4-6 weeks in length. The first week of employment consists of new employee enrollment and a business overview and observational experience. During the second and third week of employment, a CSR participates in a Customer Service Instructional Seminar sponsored by Magellan's National Clinical Training Department. The CSR Instructional Seminar includes presentations on the topics listed below. The CSR then receives account-specific training on policy and procedures, contract and benefit review, and QUEST.

Customer Service Instructional Seminar Topics:

- New Employee Orientation Program (if new hire)
- Magellan's Products/Programs
- Confidentiality and Legal Issues
- Clinical and Administrative Non-Authorization Determinations
- Continuous Quality Improvement Program
- Clinical Information Systems
- Magellan's Mission, Culture and Values, Clinical Treatment Philosophy
- Customer Service and Effective Communication Skills
- Pre-Authorization and Concurrent Review Procedures
- Clinical and Administrative Appeals
- Network
- Basic Insurance Terminology and Managed Care Concepts
- Roles & Responsibilities of Team Members
- Triage and Referral: Crisis Call Management
- Customer Comments: Compliments, Complaints and Grievances
- CSR Linkages

d. Ongoing Education

In-House Mentoring: CSRs participate in a 3-week preceptor program under the tutelage of an experienced CSR preceptor.

Call Monitoring: A senior CSR or manager listens to CSR calls as they occur. CSRs are evaluated on such parameters as greeting, confidentiality, professionalism, call management, hold and transfer techniques, and accuracy and completeness of information provided. Data collected from call monitoring is documented and immediately shared with the CSR. This quality improvement tool is used to identify individual and group training needs, as well as areas for improvement in CSR processes and procedures.

- F. How many additional claim processors and customer service representatives will you need to hire if you are awarded the State MHSA business, and how will this impact the initial level of service the State can expect?

If awarded the State account, Magellan will add 4.5 claims processing personnel (includes 3 claims processors, .5 supervisor, .5 auditor and .5 support person) and 3 CSRs to the current staff.

In order to prevent the addition of new staff to input the level of service which Magellan is committed to the State, we will:

- utilize experienced CSRs many of whom will be internally transferred and assigned to the State account
- use higher staffing levels initially to prevent any service problems in a new account
- assign and train well in advance of account implementation

- G. Describe the process established to handle written inquiries from participants and plan sponsors including tracking procedures and follow-up steps.

Handling Written Inquiries

Magellan uses Customer Service Reports and Call Tracking Reports to handle written inquiries from participants and plan sponsors. These reports provide Magellan's management teams with the ability to follow-up on member inquiries and track the history of the member calls.

Customer Service Reports: Every customer service inquiry is logged and documented according to the following categories:

- Call type
- Caller
- Reason for the call
- Disposition

Reports generated from this data include the daily Call Tracking Report, the Weekly Open Call Report, and the Monthly Call Tracking Report. The Call Tracking Report and Open Call Report capture information documented on-line into the QUEST system by CSRs and care managers. Data collected includes type and reason for call, disposition, and timeliness of response by the CSR. These reports ensure that all calls are tracked, tracking fields are completed, and routed calls are resolved in a timely manner. The Call Tracking and Open Call Reports capture the data of interest to most accounts. Member and Provider Services uses all three of these reports to monitor and improve timeliness and effectiveness of the CSRs in providing customer service to both providers and patients.

Call Tracking Reports: The Call Tracking Report is generated daily and is reviewed by the executive director and senior corporate staff. Analysis of the volume by call type provides important information on staffing needs, procedural or process changes, and other improvements needed to respond to the call patterns specific to each Magellan regional service center. Thus, an increase in complaints and grievances, or a high relative incidence of grievances at the Michigan regional service center as compared to other service centers, would lead to further investigation to identify ways to reverse that trend. Appropriate actions, depending on the nature of the complaints, could range from re-training CSRs or claims examiners, to account-specific or system-wide changes, to changes in our policies and procedures.

Similarly, increased volume of call activity within any one service area alerts management to the need for additional member or provider educational and communication activities to reduce the necessity for those calls before they occur.

H. Describe special customer services developed for the following participants:

- a) seniors
- b) non-English speaking
- c) hearing impaired
- d) visually impaired.

a. Seniors

CSRs receive training on communicating with seniors. MBM currently serves Medicare accounts and retiree populations. We place special emphasis on listening skills, patience, and ability to elicit information from older persons.

b. Non-English Speaking

For non-English speaking members, Magellan has a national agreement with Pacific Interpreters of Portland, Oregon for 24 hour/7 day telephone access to accurate, clear, and culturally sensitive interpretation of more than 100 languages. Pacific Interpreters employs skilled professional interpreters who are specially trained in customer service and in medical, insurance, legal, financial, and emergency services terminology.

c. Hearing Impaired

Magellan will serve the State's hearing impaired members through an AmeriTech toll-free TTY line.

d. Visually impaired

The Michigan regional service center uses a live operator for persons that cannot use a touch tone telephone.

- I. Describe your quality assurance or audit program for customer service, and the grievance system that will be in place for participants.

Customer Service Audit Program

Within the Customer Service Unit, the Vice President of Operations as well as senior CSRs maintain quality throughout the department through various methods described below.

Call Management System Reports

The Magellan customer service system generates historical telephone reports that provide information such as:

- The average speed of answer
- Number of abandoned calls
- Percentage of calls answered
- Percentage of all telephone trunks busy

These reports are used for quality control purposes to measure performance and productivity. They are produced on a daily, weekly, and monthly basis.

The automatic attendant logs every occurrence of an incoming call. This log is distinct from the Call Tracking Report which provides more extensive data on the nature and disposition of calls. CSRs do not have the ability to prevent logging of the call by the automatic attendant. The automatic attendant logs wrong numbers as well; it cannot discriminate between intentional and unintentional calls. However, these calls are tracked, then dropped before tallies are computed for performance monitoring purposes. Comparison of the two reports uncovers any discrepancy between calls received and calls tracked.

Call Monitoring

Call monitoring requires a senior CSR or manager to listen to CSR calls as they occur. CSRs are evaluated on such parameters as greeting, confidentiality, professionalism, call management, hold and transfer techniques, and accuracy and completeness of information provided. Data collected from call monitoring is documented and immediately shared with the CSR. This quality improvement tool is used to identify training needs, as well as areas for improvement in CSR processes and procedures.

Data Integrity Audits

Data integrity audits are conducted on information in the call tracking QUEST systems. Audits are performed to ensure that accurate and complete data is entered by CSRs, as well as to identify training needs and produce accurate data reports.

Definitions of Compliment, Complaint and Grievance

A compliment is a verbal or written expression of satisfaction with services rendered. Compliments provide valuable customer feedback regarding aspects of service or interactions with individuals that have met or exceeded customer expectations.

A complaint is an expression of dissatisfaction with services rendered. Complaints can address the following:

- Access to care or service
- Quality of care or service
- Timeliness of care or service
- Attitude and service orientation of practitioner/provider, practitioner/provider's staff, or Magellan staff
- Utilization management process
- Inaccurate or inadequate information
- Care or service rendered by practitioners/providers
- Claims payment
- Billing and collections

(Note: Complaints regarding medical necessity non-authorization determinations are managed through Magellan's *Clinical Appeals Process*.)

A grievance is a complaint defined as a grievance by the customer's health plan or a formal written complaint submitted by an official staff member of a local, state, or federal agency on behalf of the Complainant.

Note: Grievances regarding medical necessity non-authorization determinations are managed through Magellan's *Clinical Appeals Process*.)

Standard Complaint and Grievance Investigation and Resolution Process

A Magellan employee, typically a department manager, is assigned to investigate the issue, make a determination, and provide a written response within ten (10) business days of receipt of a complaint or within thirty (30) calendar days of receipt of a grievance. For verbal complaints, the resolution will be communicated verbally or in writing. For written complaints and grievances, the resolution must be communicated in writing. Standard complaint and grievance decisions may be appealed through the administrative appeal process.

First Level Administrative Appeal

For first level appeals of an administrative non-authorization, customer (or representative) complaint or grievance, an appropriately qualified Magellan manager investigates the customer's concern and makes a decision within thirty (30) calendar days of the receipt of the request for a first level appeal. A written response to the appeal is provided to the customer within the same thirty (30) day period.

Second Level Administrative Appeal (Administrative Appeal Panel)

For second level appeals, an administrative Appeal Panel is convened to conduct the review. The patient has a right to attend this review to provide information. The Panel makes a determination within thirty (30) calendar days of the receipt of the request for a second level appeal. A written response is provided to the customer within the same thirty (30) day period.

The expedited review process is conducted when the complaint or grievance issue is of a clinically urgent nature (e.g., appropriateness of referral, review of treatment, quality of care or service delivered by a network practitioner or Magellan clinical staff, etc.).

For *complaints*, the Vice President of Clinical Operations addresses and resolves the issues within twenty-four (24) hours of the receipt of the complaint. Continued investigation of related operational or practitioner/provider issues may continue beyond twenty-four (24) hours to be completed within ten (10) business days of receipt of the complaint.

For *grievances*, the Vice President of Clinical Operations addresses and resolves issues within twenty-four (24) hours of the receipt of the grievance. Continued investigation of related operational or practitioner/provider issues may continue beyond twenty-four (24) hours to be completed within thirty (30) calendar days from receipt of the grievance.

Member Grievance

Issues raised through the complaint and grievance processes receive internal investigation, resolution, documentation, and response. Magellan's formalized complaint/grievance resolution process provides:

- A consistent approach to collecting information about member and provider concerns
- A mechanism for assuring appropriate management review of concerns
- Assurance that the member/provider receives timely resolution and acceptable response
- A mechanism by which to trend comments and identify opportunities for improvement

The Vice President of Operations serves as coordinator for member complaints and grievances. However, the procedures rely on active involvement of Magellan staff in recognizing and responding to member dissatisfaction. She reviews each complaint and coordinates when necessary.

During the second quarter, MBM has received 40 complaints; 98% were resolved within ten days.

- J. Describe services available through a website, including on-line provider directories, coverage information, etc. If currently active and available for our review, provide the web address. Describe any expected enhancements.

Magellan's Internet Capabilities

The Internet has opened up unlimited possibilities, particularly in the area of behavioral health care. Magellan is using this medium to expand its availability and utility to both the member and provider community. For the member, we recognize that while many advances have occurred in the past few years, the stigma surrounding behavioral health continues to be a core issue as many in need of services do not access care or information about care as a direct result. Recognizing this and other issues of access, Magellan, working with a strategic partner, has created an enhanced, highly interactive Internet utility designed to focus on skill building and problem resolution. The dynamic potential offered through this medium is comprehensive. The interactive capability is readily available 24 hours a day, 7 days a week and includes interactive content, online provider directories, specific coverage information and available resources including those in the community and online links.

Our Internet technology allows participants accurate, current information, point-to-point referral procedures, and self-guided programs to help people help themselves. Our goal is to reach individuals with confidential assistance at home or work to help them address problems and build skills before they require a higher level of services. Our state-of-the-art interactivity empowers users and delivers essential tools directed at healthier lifestyles. This interactivity is accomplished through numerous Self-Improvement programs covering issues of daily living such as stress, depression, anxiety; personal growth topics like time management, coping with change, life planning; and health and wellness issues such as diet, nutrition, and exercise.

Our system is designed to provide something relevant to everyone. We focus on preventive, early intervention to reach people at the initial stages of the care continuum who are not presently in treatment and also as an adjunct to therapy for those who are. Research indicates that when individuals are reached early, there is a much higher predictability that they will actually make changes in their lives. The smart technology used to create our Interactive programs build upon the direct information supplied by the users designed to engage them in dialogue, allowing them to create a tailored plan to self-improvement. As such, the programs utilize conditional logic branching to demonstrate a personalized, truly interactive site unlike any other in behavioral health and well beyond purely informational sites with simple assessment tools.

Members can access these services through the following processes:

- Quick Information programs that provide straightforward, well-organized information on a wide range of health and personal development areas. Designed to provide the user with help getting started, quick facts, helpful hints, answers to frequently asked questions, and resources for further assistance.

- Plan Related Information, which is customized for the account and includes a description of benefits, how to access the program, frequently asked questions and provider directories.
- Self Assessments, which are single session, 15- to 20-minute programs asking questions, summarizing responses, and providing recommendations for addressing specific problem areas. Designed to give the user an objective appraisal of his or her problem and severity, as well as an opportunity for self-exploration and a link to available information.
- Personal Plan programs, which are single session, 20- to 30-minute programs designed to teach users about a topic or problem area and to provide tools with which the user can improve his or her situation. A typical program includes information, skill training, demonstrations, online exercises, and homework.
- Coached Series programs that take interactive online services one step further. The Coach Series offers multi-session programs with individual coaching assembled and monitored by a licensed mental health professional. These 6- to 10-online session models begin with an online questionnaire utilizing the principles of cognitive behavior therapy that then offers coaching and feedback from the mental health counselor through the course of the sessions.

In addition to the available programs, there is an additional range of self-help options including Community Resources links and information, Live Chat and Discussion Groups, Message Boards, Click! Online Magazine. Each of these services provide vehicles to ask and respond to questions on health and skill-building issues. The Discussion Rooms also feature a monthly guest speaker who is a leading expert in the particular topic area being discussed.

The system architecture has been built and integrated using the latest Web technologies wherein each functional system is structured using a three-tier design examined and approved by Microsoft. The front tier runs on Microsoft Internet Information Server (IIS 4.0) and contains Active Server Pages (ASP), VBScript, JavaScript and HTML that is compliant with all browsers currently in use. The middle tier, which is key to achieving necessary scalability, was built using powerful DCOM objects that run on Microsoft Transaction Server (MTS) and communicates with the database. The back tier or database contains hundreds of tables running on Microsoft Sequel Server.

Magellan via Epotec* works with EMC2, a leading national Web hosting service and data management company, and VeriSign, the world leader in encryption technology who provides the security. We utilize 40-bit data encryption whenever personal data is transferred across the Internet using a secure server certificate from VeriSign. (Additional information on how secure server certificates function is available at 222.verisign.com). Further, the database is not directly connected to the Internet rather it resides on a machine completely separate from the Web and Transaction servers. We access it and transfer data to and from it via a virtual private network (VPN) using 128-bit RSA data encryption.

Enhancements

Our system will soon offer a client specific Messaging System that will allow Magellan's care managers to communicate directly with participants enrolled in the system. A member would send a message through the system. It then enters a queue where the next available care manager can handle it. This provides a confidentiality aspect not available through an e-mail system and can be utilized anywhere in the world.

Magellan's vision for online connectivity with our providers includes the development of an enhanced platform utilizing Practice Management Tools for providers to access eligibility data, claims status, treatment planning and scheduling tools online in real-time. Our site also provides claims submission and houses Magellan's Medical Necessity Criteria, Clinical Practice Guidelines, Provider Handbook, Provider Focus, News and Events.

As this project is enhanced, we intend to launch private communication centers (Chat Rooms) for peers and industry experts and an extensive professional resources searchable database on associations, journal articles, and more. Through this effort, we further intend to offer continuing education programs via online courses for all disciplines.

In addition, providers can utilize the consumer content portion of our site to serve as an adjunct to traditional therapy. Participants access our site making use of the personal plans and/or self-assessment programs as homework between therapy sessions. This feature offers hands-on activities informing and empowering individuals to assist them in advancing through treatment.

A demonstration of the website can be found at www.Magellancare.com. Upon request, we can provide the State with a CD-ROM with a demonstration of the website.

The site content which we have described is not available on our public site, but is instead tailored for each account we serve. While we have supplied some screen shots in Appendix C, these do not adequately demonstrate the depth of content and interactivity available. We would, however, welcome the opportunity to discuss the scope of our services with the State at any time.

- K. Describe all methods used to determine participant satisfaction. Indicate the frequency of surveys. Indicate if account-specific satisfaction surveys are available. Provide results of the most recent book-of-business survey.

Patient Satisfaction

Magellan utilizes a number of methods to determine participant satisfaction. We conduct account specific satisfaction surveys for all of our state accounts. The Patient Satisfaction Survey is included in Appendix D.

Office Survey

The Client Office Visit Questionnaire (COVQ) (GHAA, Second Edition) includes a nine-item satisfaction battery designed to assess the member's experience with a specific provider. The survey is conducted quarterly. During a one-week period, the instrument is distributed personally after the session, to all members receiving an office visit with a Magellan network provider. This method captures satisfaction at all points across the course of treatment (initial visit, as well as ongoing therapy). The questionnaire includes prepaid postage and is preaddressed to Magellan to encourage candid responses and to improve response rate. Items in the COVQ assess the following factors:

- Access and availability of care
- Member/provider communication
- Interpersonal care
- Overall quality of care

Telephone Survey

While the written surveys provide reliable results, the telephone survey increases frequency and efficiency in collecting this feedback. One significant drawback of the mail survey is the inability to collect information from non-respondents. The telephone survey is conducted on a yearly basis and is administered to random samples of members receiving care during a selected 3 to 6 month period. Application of the telephone survey helps collect accurate and timely information and accomplishes the following objectives:

- **Increased response rate:** Over 70 percent of the respondents contacted participated, resulting in a sample size representing from 25 to 45 percent of the care delivered.
- **Improved data collection:** Information is collected quickly and efficiently. Interim summary results can be reported almost immediately after survey administration. Expedited turnaround time for results obtained through the telephone survey increases our ability to track changes in member perceptions and thus address problem areas more quickly.
- **Increased efficiency:** Surveys are administered by a third-party with oversight provided by Magellan management, so that more time can be invested in evaluation and follow-up planning.
- **Enhanced customer relations opportunities:** This method increases contact with the member, resulting in additional opportunities for improving customer relations and obtaining more member input.
- **Widened survey sample:** This technique captures information from possibly under-represented groups, such as those with literacy problems, who may not complete and return a written instrument.

Analysis and Application of Survey Results

Survey findings are presented to the MBM Quality Improvement Committee, which then recommends actions to improve our responsiveness to member needs. Member satisfaction results also are shared with the providers who treated those members to close the feedback loop and to encourage improvement in services provided.

Results of Recent Survey

Analysis of the 1998 and 1999 results of the MBM patient survey showed positive results. In 1998, 95 percent were satisfied with their provider; in 1999, 94 percent expressed provider satisfaction. The survey also asks the members for their overall satisfaction with the services received from Magellan; in 1998 and 1999, 96 percent expressed overall satisfaction. The survey also includes questions about the provider office, office staff, and customer service staff. In all categories, Magellan received over 85 percent satisfaction score.

- L. The MSHA program requires precertification of inpatient admissions, discharge planning, concurrent review, and case management. Describe your firm's approach and capabilities in administering these plan features.

Administering Plan Features

Magellan's approach to the review of inpatient care is quite vigilant, as our managed care philosophy is based on providing care in the most clinically-appropriate setting. We have a multi-disciplinary team of professionals highly familiar with facilities, programs and providers in Michigan. One of the advantages of our presence in the state is the provider community's familiarity with our clinical protocols and medical necessity criteria.

Inpatient and Intensive Care Authorization and Review

The care manager initially reviews all requests for inpatient care. If the member meets our medical necessity criteria for inpatient admission, the care manager certifies approved days of inpatient care; enters all required data into Magellan's clinical information system; and generates written confirmation of the authorization to the patient, provider, and facility.

If the care manager concludes that the patient does not meet our inpatient admission criteria, s/he refers the case to a physician advisor. The physician advisor independently reviews the case, confers with the treating provider, and makes a determination regarding medical necessity. If the physician advisor concludes that inpatient treatment is medically necessary, s/he notifies the provider. The care manager then authorizes the approved days of treatment and sends written notification to the member and provider. In cases where the physician advisor concludes that inpatient care is not medically necessary, s/he works with the provider to develop an appropriate alternative treatment plan. Only a physician advisor may make the determination that a case does not meet Magellan's medical necessity criteria for a specific level of care.

For non-emergency or elective inpatient admissions, Magellan requires notification within 24 hours of admission. For emergency admissions, we require notification via the toll-free help line at the time of the admission or as soon as possible thereafter. These guidelines can be modified to accommodate the State's preferences.

Magellan Behavioral of Michigan follows the "prudent layperson" rule when reviewing an emergency evaluation and treatment. A prudent layperson is considered to be an individual who is without medical training and who draws on his or her practical experience when making a decision regarding the need for emergency treatment. A prudent layperson is considered to have acted "reasonably" if other similarly-situated laypersons would have believed—on the basis of observing the clinical symptoms at hand—that emergency treatment was necessary. In these cases, Magellan does not withhold payment, even though there was no prior authorization for the emergency.

Concurrent Review. For concurrent reviews, the care manager schedules review dates to occur prior to expiration of the previous authorization. Reviews usually are conducted by telephone, but may be conducted on-site. In the course of the review, the care manager obtains the following information from the provider:

- Reason for the request for extension
- Treatment progress to date
- Treatment goals and approach
- Requested length of extension
- Discharge plans

The care manager then evaluates the appropriateness of the treatment extension request, considering the following:

- Diagnosis and focus of treatment
- Treatment goals and objectives
- Current standards of practice
- Duration of treatment
- Evaluation of progress
- Evaluation of level of care

Care managers approve the appropriate number days per concurrent review, based on Magellan's medical necessity guidelines. A formalized, two-tiered appeals process is available to patients and providers who wish to challenge authorization determinations. Once internal appeals are exhausted, an external appeal through the health plan may be filed. An external appeal to the health plan may be initiated at any time prior to exhausting the Magellan appeal process, if the member desires. The health plan decision always supercedes Magellan's decision.

Discharge Planning and Case Management

All members who receive inpatient care are closely monitored in terms of aftercare and adherence to the discharge plan. Our clinical information system includes prompts regarding appointment scheduling and attendance. Care managers are actively involved in this process.

Discharge planning is initiated when an inpatient episode begins so that when discharge occurs, the appropriate treatment authorization is already completed, allowing the patient an uninterrupted transition to an appropriate level of care.

Prior to discharge, Magellan arranges a follow up outpatient appointment with a network provider as soon as clinically indicated. The treatment plan, with recommendations for discharge by the provider, is discussed with the patient so she/he knows that follow-up care is being provided. The Care Manager then coordinates the outpatient referral and follows up to ensure that the transition was completed, and that treatment objectives are achieved. Care managers within the care management department are responsible for follow-up outreach and for ensuring that patients have a well integrated proactive case management plan. For complex cases, "aggressive" follow-up services (e.g., setting appointments, assisting with transportation, dispatching visiting nurses to administer medications when necessary) are often necessary. For substance abuse cases, follow-up will occur at 6, 12, 18 and 24 months.

Our primary objectives for discharge planning and follow up are to:

- assist patients in navigating a sometimes fragmented service delivery system
- coordinate available resources along the behavioral healthcare continuum
- coordinate behavioral health and medical care
- ensure access to an appropriate array of services

We utilize the same discharge follow up process for substance abuse cases. However, 12 step programs are included in the discharge plan and follow up includes review of program participation.

Magellan has developed an Intensive Care Management (ICM) program to serve members who are likely to have difficulty achieving, consolidating, and maintaining treatment gains. The ICM program's purpose is to improve the efficacy of treatment through more frequent contact with—and more intensive coordination among—the member, provider(s), family members, and others within the member's support system. Candidates for ICM may be identified at any of the following points in the treatment process: during an initial assessment, at the time of a concurrent review, as part of a discharge and aftercare plan, or through the review of claims and authorization reports.

Once the member is identified, his or her case is referred to the ICM team for review and assignment to a care manager (the ICM team minimally includes the vice president of medical services, Mike Faumann, M.D., or the vice president of clinical operations, Evelyn Thomas, an intensive care manager, and other multi-disciplinary representation). The care manager collects all of the available clinical and administrative information about the member and

develops an ICM care management plan that includes at least the following: a summary of the presenting problem and medication history, ICM criteria met by the member, treatment objectives, proposed interventions, and regular progress updates.

Outpatient Authorization

For the State account, all requests for outpatient services by a member or from a network provider will receive an automatic authorization for 8 visits. If additional care is indicated (past the expiration of the authorization), the provider submits a Treatment Request Form (TRF). The TRF can be submitted electronically, by mail or by fax.

The Magellan TRF was created to standardize documentation of

- DSM IV diagnoses
- symptoms presented by a patient
- symptoms targeted for intervention
- the planned interventions
- improvement achieved over the course of treatment

The TRF allows automated scanning and scoring. The TRF uses clinical and administrative algorithms to differentiate routine cases, which can be authorized with minimal review from those cases which require more intensive review. For cases meeting the scoring criteria, the provider will receive an authorization, electronically and by mail. It will not be necessary for the clinician to conduct a further telephonic review. The TRF minimizes the amount of confidential patient information exchanged between the provider and Magellan and maximizes turnaround time for treatment review. Moreover, it focuses care management intervention on the cases requiring the most attention.

The clinical algorithms used in scanning the TRF were designed to:

- assess congruence of reported symptoms and diagnoses
- identify patients to be at relatively higher risk and to determine if the planned intervention is appropriate given the risk status
- incorporate clinical practice guidelines into the evaluation of planned treatment
- track progress in treatment based on changes in symptoms and severity over time

The TRF database is a valuable resource for identifying trends in the delivery of outpatient services and evaluating provider and care manager performance.

IV-D QUESTIONNAIRE**3. Utilization Review/Care Management**

- A. How will a State care management unit be staffed and where will they be located? Describe the education and experience of staff responsible for utilization and care management. What are your caseload standards for utilization review/care management staff?

The care management staff will be located at Magellan Health of Michigan, which is located in Farmington Hills, MI. Magellan employs two categories of personnel to conduct care management reviews: care managers and physician advisors. Care managers report to the vice president of clinical operations. Physician Advisors report to the vice president of medical services.

Care Manager Qualifications

Magellan's care managers are psychologists, social workers, psychiatric nurses, and licensed professional counselors who meet the following qualifications:

- Master's degree or doctorate from an accredited program
- Current licensure with appropriate state agencies
- Minimum of five years of previous experience in a psychiatric and/or substance abuse setting
- Two years of post-graduate experience under the supervision of a licensed psychiatrist, psychologist, social worker, CNS, or other master's prepared therapist
- Managed care experience is preferred

Physician Advisor Qualifications

All Magellan physician advisors must meet the following requirements:

- Current licensure in the state in which they practice and ability to meet all Magellan credentialing criteria
- Completion of a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association
- Certification by the American Board of Psychiatry and Neurology (or certification in Osteopathic Medicine)
- Minimum of five years of relevant post-residency clinical experience in the field in which they are reviewing

Physician advisors who review substance abuse cases must be qualified as psychiatrists as described above or have completed an ACGME-accredited residency and obtained specialty board certification. Specialties represented by physician advisors include substance abuse and child, adolescent, adult, and geriatric psychiatry. We are careful to select physician advisors who demonstrate the ability to negotiate and interact positively and effectively with their peers.

Magellan's staffing ratio for utilization review/care managers is 1:35,000. If awarded the State contract, we will increase our care manager staff to ensure adequate coverage for your members. The current caseload standard for care managers in MBM is 25.

- B. Does the automated records system provide care managers with a clear history of previous services provided to the member? Does the information system provide alerts to care managers regarding key issues such as risk level, co-morbid medical conditions, or special needs?

The QUEST (Quality Utilization and Enhanced System Tracking) system is an internally developed clinical utilization and tracking system comprehensive enough to manage patient risk, care, and benefits. All clinical transactions are placed in a transaction log file, which the care managers can access. This allows clinicians to view chronological progressions of the patient to measure clinical progress, and/or regression as the patient moves through the levels of care. The system provides edits to alert care managers to any key issues such as risk level, co-morbid medical conditions, need for a follow-up appointment or case review. An integral part of the system is the follow up queue which creates automatic reminders based on Magellan performance standards; for e.g., ambulatory follow-up after an intensive level of care is automatically scheduled and monitored.

- C. Describe the on-going treatment review process for intensive levels and outpatient care. What are your standards for frequency of treatment review?

Magellan closely monitors all inpatient admissions and conducts extensive admission review and concurrent review. Our care managers are supported by physician advisors in the review process for all levels of inpatient care. As members move through the continuum, or enter care at an outpatient intensive level, they are monitored with a high level scrutiny. Concurrent reviews are regularly scheduled and treatment planning conferences are initiated for complex or hard to discharge cases.

Intensive Case Management

Magellan has developed an Intensive Care Management (ICM) program to serve members who are likely to have difficulty achieving, consolidating, and maintaining treatment gains. The ICM program's purpose is to improve the efficacy of treatment through more frequent contact with—and more intensive coordination among—the member, provider(s), family members, and others within the member's support system. Candidates for ICM may be identified at any of the following points in the treatment process: during an initial assessment, at the time of a concurrent review, as part of a discharge and aftercare plan, or through the review of claims and authorization reports.

Once the member is identified, his or her case is referred to the ICM team for review and assignment to a care manager (the ICM team minimally includes the vice president of medical services, Mike Faumann, M.D., or the vice president of clinical operations, Evelyn Thomas, an intensive care manager, and other multi-disciplinary representation). The care manager collects all of the available clinical and administrative information about the member and develops an ICM care management plan that includes at least the following: a summary of the presenting problem and medication history, ICM criteria met by the member, treatment objectives, proposed interventions, and regular progress updates.

Possible objectives of the ICM care management plan include:

- Designing interventions to support member treatment gains
- Preventing inappropriate hospital re-admissions
- Improving treatment compliance
- Decreasing suicidal/homicidal gestures
- Addressing health complications as part of the behavioral health treatment plan
- Decreasing psychotic episodes
- Facilitating substance abuse treatment, when appropriate
- Improving the coordination of care among multiple providers
- Confirming diagnostic accuracy and appropriateness of treatment goals
- Facilitating progress in treatment rather than maintaining conditions that are amenable to improvement
- Coordinating treatment intensity and level of care with the member's current level of distress

The ICM team reviews the collected information and the ICM care management plan and provides consultations, as needed; the frequency of case review is based upon the acuity of the member's mental health condition and progress in achieving ICM care management goals and objectives. Documentation of the ICM team review is maintained in the member's care management record.

The care manager is responsible for overseeing the implementation of the ICM care management plan. When clinically appropriate and with the member's consent, the care manager may bring together other treatment providers, the member, family members, individuals from the member's support system, and appropriate agencies to participate in treatment planning. When the care manager determines that the ICM program discharge criteria have been met, the member's case is taken back to the ICM team for a final determination of continued participation or discharge from the ICM program.

- D. Describe your discharge planning/transition to alternative levels of care process for mental health. Describe your discharge planning/transition to alternative levels of care process for chemical dependency. Provide specific information about the level of direct involvement of your organization's clinical staff in follow-up activities.

Helping patients make the transition between treatment modalities is a crucial element of effective clinical management. Discharge planning is initiated when an inpatient episode begins so that when discharge occurs, the appropriate treatment authorization is already completed, allowing the patient an uninterrupted transition to an appropriate level of care. Magellan's comprehensive policy regarding discharge planning is included in Appendix E.

Prior to discharge, Magellan arranges a follow up outpatient appointment with a network provider as soon as clinically indicated. The treatment plan, with recommendations for discharge by the provider, is discussed with the patient so she/he knows that follow-up care is being provided. The Care Manager then coordinates the outpatient referral and follows up to ensure that the transition was completed, and that treatment objectives are achieved. Care managers within the care management department are responsible for follow-up outreach and for ensuring that patients have a well integrated proactive case management plan. For complex cases, "aggressive" follow-up services (e.g., setting appointments, assisting with transportation, dispatching visiting nurses to administer medications when necessary) are often necessary. For substance abuse cases, follow-up will occur at 6, 12, 18 and 24 months.

Our primary objectives for discharge planning and follow up are to:

- assist patients in navigating a sometimes fragmented service delivery system
- coordinate available resources along the behavioral healthcare continuum
- coordinate behavioral health and medical care
- ensure access to an appropriate array of services

We utilize the same discharge follow up process for substance abuse cases. However, 12 step programs are included in the discharge plan and follow up includes review of program participation. Follow up for substance abuse cases also may occur for a longer period of time based on complexity and job classification.

- E. Describe how your organization interfaces with disability carriers in order to maximize employee performance. Describe any specific collaborative efforts your organization is pursuing with these suppliers.

Currently, MBM does not interface with a disability carrier, but we are willing to participate in such an effort at the States' request. In some of our other State accounts, we work with the disability carrier often in a consultative role. Magellan also has developed a psychiatric disability program in which we work with cases requesting or approved for mental health disability to accelerate return to the workforce.

- F. What information is readily available to assessment and referral personnel to assist them in making treatment recommendations and referrals to specific network providers? Identify capacity to make referrals based on special requests or need. Is provider-profiling information available on line?

In order to accommodate the special and cultural needs and preferences of members, the Magellan's Provider Application captures providers' general and specific skills (such as fluency in other languages). Information about gender and ethnic background is provided voluntarily on the Provider Application. This information is entered into the provider and credentialing database, where it can be accessed by care managers in the process of providing a referral, allowing the care managers to match patients with practitioners in order to meet the patients' special needs or preferences.

The specialized needs of individual members are assessed at the time of initial contact with the care manager. This includes asking callers about their preferences in terms of provider geographic location, credentialing level (e.g., physician, psychologist, master's level), specialty service needs, appointment times, gender, ethnic background (as needed), language fluency (as needed) and other special needs or preferences. For hearing impaired members, Magellan utilizes Ameritech's Special Needs TTY service to facilitate communication. During the assessment and referral process, care managers use Magellan's provider search which allows them to search for practitioners/providers based on:

- Client/member preferences and treatment needs
- Requests for:
 - Gender specific practitioners
 - Practitioners of a specific ethnicity
 - Practitioners with expertise with certain age groups such as children, adolescents and the elderly
 - Language specialties
 - Practitioner discipline and degree
 - Clinical specialties (i.e., age, type of treatment)

The most recent census data indicate that in the Michigan counties served by Magellan, 88 percent of the adult population speak English as a primary language. The next most frequently spoken primary language is Spanish, with approximately 2 percent of the population speaking Spanish as their primary language. A variety of other languages, including Chinese, Japanese, Polish, German and Arabic, each representing less than 1 percent of the population constitute the remaining 10 percent. Although the number of members with a primary language other than English are low, Magellan strives to include bilingual or multi-lingual practitioners in its network, and considers language and cultural diversity in its consideration of practitioner requests to join the network. Over the past year, qualified practitioners have been approved for inclusion in the network on the basis of linguistics (Spanish, Italian), culture (African American, Spanish) and religious orientation (Christian Counselors).

Magellan conducts regular meetings with the Provider Advisory Group (PAG) and the Labor Advisory Group (LAG). During these meetings, we gather information regarding the special needs of the members. We use this information to ensure that our networks meet the needs of the members.

A care manager sits on these committees to provide information on requests for specific types of ethnic/cultural composition of providers as expressed by members in the intake and referral process.

Magellan uses both qualitative and quantitative data to monitor and manage our credentialed providers. Based on the results of this analysis, providers can be placed into profiling tiers that can be used in the referral process as well as in determining which providers may need remedial attention.

Profiling data includes information such as:

- the patient's subjective experience with the provider
- the appropriateness of the care based on clinical need
- the results of the care
- utilization efficiency compared to peers
- compliance with administrative protocols

Our referral system includes information of the profile tier of the provider.

Tiers include:

- A **Magellan Preferred Provider (MPP)** is a provider who demonstrates high quality across the matrix of profiling elements. These would be providers who achieve a good clinical outcome, who are perceived as caring and responsive by patients, whose utilization patterns are within norms, and who cooperate with administrative protocols. An MPP provider would receive priority for referrals.
- A **Magellan Provider (MP)** is a provider for whom there is sufficient information to suggest that s/he may have attributes or qualities that suggest high performance. Because many providers do not treat high volumes of Magellan members, it can be difficult to develop a reliable profile. An MP status allows the provider to receive a higher priority in terms of referrals than an un-rated provider, making it more possible to collect enough data to generate a good profile.
- A **credentialed provider** is a provider who has met Magellan's stringent credentialing criteria, but who has insufficient patient volume to develop a meaningful profile. There is no qualitative weighting assumed by this designation; rather, there is insufficient information to make a determination. These providers can still receive referrals and serve members who self-refer.

- A **flagged provider** is a provider who has been brought to the attention of the PPRC as a result of questionable practices, high volumes of complaints (or a single serious complaint), or repeated administrative non-compliance. The provider is notified and referrals are suspended until the Provider Peer Review Committee can make a determination regarding the provider's continued status with Magellan. Remedial interventions will be offered if it appears that the issues can be resolved through provider education.

G. Describe the process by which providers and employees may appeal authorization and/or utilization management decisions at all levels of the appeals process under and ERISA plan. What percentage of decisions are denied/appealed?

First Level Clinical Appeal

For a standard first level appeal of a case that has been denied after a treatment episode or admission is completed, the provider, facility (if applicable), or patient/guardian may request an appeal of that decision, verbally or in writing. The general steps are:

- A physician advisor retrospectively reviews the complete medical record (and any additional information that may have been supplied) according to the Magellan medical necessity criteria
- The advisor recommends authorization or non-certification of the care within thirty days of receipt of all required information
- Written notification of the review determination is sent to the patient/guardian, provider, and facility (if applicable) within the thirty-day review timeframe

If the patient is currently in treatment (or if treatment is imminent), an expedited first level appeal may be requested by the patient/guardian, provider, or facility (if applicable). The general steps are:

- The physician advisor reviews the request for an expedited first level appeal with all relevant documentation
- The advisor attempts to contact the attending or treating clinician within one business day of receipt of the request
- The advisor informs the attending or treating clinician of his/her appeal determination at the time of the review
- Written notification of the first level appeal determination is sent to the patient/guardian, provider, and facility (if applicable) within one business day of the review

For both expedited and standard first level appeals, if a non-authorization determination is upheld, the written notification includes the name of the physician advisor, the clinical rationale, and a description of the standard second level appeal process.

Second Level Clinical Appeal

The provider, facility (if applicable), or patient/guardian may request a standard second level appeal verbally or in writing within seventy days of notification of the first level appeal determination. The Appeal Coordinator informs the appealing party of the right to submit additional written information for review to the clinical appeal panel and to appear before the panel in person or by telephone. The general steps are:

- A clinical appeal panel is convened to review the medical record and any additional information submitted for consideration
- If the first level appeal was an expedited clinical appeal process, the panel is comprised of at least one physician advisor and an additional physician advisor
- If the first level appeal was a standard clinical appeal process, the panel is comprised of at least one physician advisor and an additional Magellan staff member who is appropriate to the case under review
- Review is completed within thirty days of receipt of the request and all of the information required to conduct the review
- Written notification of the clinical appeal determination is sent to the patient/ guardian, provider, and facility (if applicable) within the thirty day review timeframe

If the patient is currently in treatment (or if treatment is imminent), the second level appeal may be expedited in accordance with the clinical urgency of the request and the patient's clinical condition.

For both expedited and standard second level appeals, if a non-authorization determination is upheld, the written notification includes the name of the reviewers, the clinical rationale, and a description of any applicable appeal mechanism.

H. How are emergency inpatient admissions managed, both during regular hours and during weekends or after hours? How does your organization define "emergency" for a psychiatric and for a chemical dependency conditions?

Emergency inpatient admissions are managed in the same manner on a 24 hour, 7 days a week basis.

Magellan defines a non-life-threatening emergency for both mental health and substance abuse as a situation in which a member states or implies that s/he may do harm to self or others, but is able to maintain impulse control for several hours. In this type of emergent situation, we require that the member be seen face to face by a provider. The care manager identifies a network crisis center or facility who is able to provide crisis intervention services and who is an appropriate match for the patient in terms of clinical specialty, geographic proximity, and rapid availability. Additionally, the care manager evaluates the member's transportation situation, offering assistance if needed in making arrangements for safe transport to the evaluation setting.

Life-threatening emergencies are situations in which a member threatens imminent harm to self or others and is unable to control these impulses. Magellan provides immediate assistance that results in delivery of face-to-face services within one hour. Depending upon the nature of the emergency, the evaluation may be conducted in an office-based setting or in a medically secure environment. In situations of acute crisis where the care manager has accessed 911 services, the destination facility calls the toll-free help line for authorization when the patient arrives. If a member or provider calls prior to an admission, a referral to an emergency screening site is made and the care manager speaks to the assessing provider within one hour of the assessment.

Following all emergency referrals that result in inpatient admissions, the care manager speaks with the facility on the day of admission or the next working day to discuss patient diagnosis, appropriateness of the treatment plan, and discharge planning options. Similarly, the care manager follows up on emergent outpatient referrals, contacting the designated provider to verify that the patient kept the appointment and to discuss mutual clinical concerns.

Under no circumstances would Magellan deny care to a member needing emergency services.

I. What is the standard practice for professional clinical backup for telephone intake staff in the event of crisis calls?

Our care managers are master's- and doctoral-level clinicians who are available on site, around the clock, 365 days a year, for crisis intervention, triage, and referral. As licensed clinicians, they have both the formal training and the experience to handle most crisis situations. However, if a situation arises where psychiatric back-up might be helpful, our care managers have 24-hour access to physician advisors.

Care managers also provide clinical back up to each other in the event that one needs to place a call to local emergency services while the other remains on the line uninterrupted with a caller experiencing an acute crisis.

IV-D QUESTIONNAIRE**4. Customer Satisfaction**

- A. Describe your approach, including survey methodology, for assessing patient satisfaction. "Patient satisfaction" refers to satisfaction with not only services provided by the mental health plan administrator but also services rendered by the provider.

Magellan conducts patient satisfaction surveys of all of our accounts. To gather the maximum amount of data and patient feedback, we conduct surveys by telephone for random samples of patients who were treated during a selected three to six month period during the year, resulting in a sample size representing from 15 to 45 percent of the care delivered. A representative sample is selected based on the proportion of patients stratified by age, gender, and type of insurance program. Selection of the sample is based on the survey research firm's estimations of error and power required to obtain a statistically valid sample. Sample size is determined based on the expected rate of non-response in order to yield approximately 125 to 150 completed surveys for each comparison group. Our survey looks at a variety of issues including ease of access, administrative services, performance of Magellan staff and network services including provider access, interpersonal skills and expertise.

A copy of Magellan's standard patient satisfaction survey can be found in Appendix D.

- B. How do you monitor your network providers' (practitioners as well as facilities) satisfaction with their working relationship with you? Provide a copy of the survey instrument and a summary of the most recent survey results. What is the typical response rate? Give an example of a complaint from providers that you addressed during the last year and resolutions to that complaint.

Magellan uses input from its yearly provider satisfaction survey and its monthly meeting of its Provider Advisory Group to monitor network satisfaction.

Provider Satisfaction Surveys

Magellan Behavioral of Michigan administers an annual provider satisfaction survey. The survey is given to a random, stratified sample of providers who have received an authorization for care for a Magellan participant within the previous 12 months. The surveys are mailed along with a cover letter and a postage-paid return envelope to all qualifying providers. Providers are also sent a reminder letter urging them to participate in the survey. The surveys are returned to MBM where they are processed. In 1999, the Magellan provider survey captured 29 percent of the providers in the network. A copy of the provider satisfaction survey can be found in Appendix F. The survey's major objectives are to measure and assess trends in provider perceptions of Magellan with respect to:

- Overall satisfaction with programs and services
- Timeliness, accuracy, and responsiveness of communications and administrative services

- Accessibility
- Provider information on policies and procedures
- Utilization and care management procedures
- Treatment review

The survey instrument is a 19-item satisfaction battery (17 provider satisfaction survey items and two items to assess provider perceptions of patient satisfaction). Four items ascertain experience with Magellan relative to other managed care companies. One open-ended question asks for additional provider comments.

The most recent provider satisfaction survey indicated that the majority of providers surveyed were satisfied with Magellan. In fact, 76 percent were satisfied with Magellan and 74 percent felt that working with Magellan is more positive than working with other MBHOs. Specifically, they were pleased with Magellan relative to other behavioral health organizations as well as with access to care managers; clarity of procedures, treatment standards, and medical necessity criteria; and comprehensiveness of the provider training and communication materials (including the Provider Handbook and quarterly provider newsletters). Based on the 1997 provider survey, Magellan simplified treatment authorization procedures in 1998. This resulted in statistically significant improvement in satisfaction in both 1998 and 1999.

Provider Advisory Group (PAG). The Provider Advisory Group has been established to obtain provider input into Michigan Health of Michigan operations. Provider Advisory Group membership is as varied as possible and includes both inpatient and outpatient providers. Outpatient providers represent a variety of disciplines and includes MDs, PhDs and master's level social workers. Inpatient providers include representatives of inpatient psychiatric hospitals, partial hospitalization programs and residential treatment centers.

Recent activities of the PAG include:

- Reviewing and providing input on policies
- Review and discussion of prevention activities, quality improvement results, and utilization management activities, including PCP communication initiatives and appointment access
- Discussion of network/credentialing/fee schedule issues
- Discussion of current NCQA activities
- Analysis and discussion of patient and provider satisfaction survey results
- Systems opportunities, i.e., exchange of information via the Internet

IV-D QUESTIONNAIRE

5. Data Reporting

- A. Provide a sample of your Standard Report Package and summarize the title, purpose and frequency of each report in a separate chart. Indicate availability of reports on tape, diskette, Internet, or on-line transmittal.

Reporting Package

Magellan has provided a sample of our Standard Report Package as Appendix G. This package contains the title and purpose of each area in the report. It is submitted with an executive summary of significant activities, issues or problems addressed in the reporting period, or anticipated in the future. If awarded the contract, our account implementation team will work with the State to finalize the set of reports that will meet the needs of your plan, and will produce and present these reports on a monthly, quarterly, or annual basis. Magellan provides reports to our clients on tape, diskette, Internet, or on-line transmittal. We will be happy to provide the State with reports that meet your format needs.

Figure IV-D.5-1 below summarizes the types of reports which Magellan can provide to the State.

Figure IV-D.5-1: Summary of Reports

Name of Report	Purpose of Report	Frequency of Report
<p>Claims Paid per users, enrollees, and covered lives by enrollee category and enrollee/dependent category</p>	<p>The report will summarize by division, level of care and enrollee status the amount submitted, amount allowed, and amount paid for services. This report also gives the ratios of these amounts per user, enrollee and covered lives.</p>	<p>Quarterly</p>
<p>Claims paid by unit of service in and out of network</p>	<p>This is a three part report which:</p> <ol style="list-style-type: none"> 1. summarizes across all levels of care and plans, the network status of users and the dollar amounts submitted, allowed and paid for the report date range. 2. summarizes by plan type, level of care and network status the amount submitted, allowed and paid for services. It also gives the ratios of these amounts per discharge and day. Statistics of number of users, discharges and days are also presented for each group. The only levels of care displayed in this report are inpatient, residential and partial hospitalization. 3. summarizes information similar to that found in the second section for the added breakout of provider degree. 	<p>Quarterly</p>



Figure IV-D.5-1: Summary of Reports (continued)

Name of Report	Purpose of Report	Frequency of Report
Claims by principle diagnosis	The report will summarize by level of care and principle diagnosis the amount submitted, amount allowed and the amount paid for services.	Quarterly
Lag Study Report	The report will summarize by level of care, the number of claims paid and incurred over a timeline.	Quarterly
Claims paid by patient age and gender	The report will summarize by level of care, age group, gender, eligibility status and MH/SA the characteristics of paid claims for the report period. The report also summarizes the percent of claims for MH/SA and the amount paid for each.	Quarterly
Utilization by enrollee/dependent category, gender and age	The report summarizes utilization statistics for enrollees/dependents broken out by gender, age group and level of care.	Quarterly
Activity Summary - Utilization by customer groups	The report summarizes by plan type, MH/SA and level of care, as measured by paid claims data.	Quarterly
Utilization by principle diagnosis	The report summarizes by level of care and disorder group, the utilization as reported in claims data.	Quarterly
Activity Summary - Authorizations by enrollee category	The report summarizes by division, MH/SA and level of care, activity as measured by authorization clinical data.	Quarterly
Authorization encounter summary	The report summarizes by division and level of care, the number of cases by client category and MH/CD.	Quarterly
Inpatient/Residential treatment average length of stay analysis	The report will summarize the average length of stay, based on clinical data for inpatient and residential treatment, broken out by company division, MH/SA/Combined, and relation to employee.	Quarterly
Inpatient readmission rates	The report summarizes the number of readmissions for inpatients by division and client category.	Quarterly and Monthly
Managed Care Authorization Activity Summary	This report summarizes by division, MH/SA and level of care, activity as measured by authorization clinical data.	Quarterly
EAP/MMHC Average Lengths of Stay by care and diagnosis	This report gives average lengths of stay for all authorized encounters that are closed during the report period broken out by discharge diagnosis category and level of care.	Quarterly and Monthly

Figure IV-D.5-1: Summary of Reports (continued)

Name of Report	Purpose of Report	Frequency of Report
Average Length of stay and closing resolution	The report captures the number of assessed problems by whether an EAP case is opened or closed. The report also supplies the total number of kept sessions and the average length of stay for each assessed problem.	Quarterly and Monthly
Demographics by job category	The report will summarize the number of first encounters that occurred during the reporting period for each job category.	Quarterly and Monthly
Demographics by gender	The report summarizes the number of first encounters, which occurred during the reporting period for each gender.	Quarterly and Monthly
Demographics by age category	The report summarizes the number of first encounters which occurred during the reporting period for each age category.	Quarterly and Monthly
Demographics by organizations divisions	The report summarizes the number of first encounters, which occurred during the reporting period for each organization division.	Quarterly and Monthly

B. Provide a sample or description of additional reporting capabilities. Information on fees should be provided as part of the Price Proposal (IV-G).

Additional Reporting Capabilities

Magellan has provided a sample reporting package, which details our reporting capabilities in Appendix G. Currently, we are providing other additional reporting on a regular basis for State accounts with such features such as high-risk cases, member penetrations by treatment level and quarterly Geo Access reports. Our extensive reporting abilities enable us to provide a variety of custom reports. Using Client-server technology (Windows NT, Windows 95, Microsoft SQL Server) provides a flexible and cost-effective means of addressing special user interface, reporting, and data interchange capabilities. Extracts can be created with claim, provider, membership, and authorization data and have been created for various Magellan accounts/clients. All reports have a number of user defined fields allowing for 'standard' customization. If reporting needs exceed the flexibility of the system, internal Information Systems resources can provide user defined reports and/or files. These extracts have been created as one-time submissions and have also been established as jobs to run on a scheduled basis.

Magellan will be pleased to collaborate with the State on the design and development of data downloads and ad hoc reports.

Fees for Customized Reporting

Magellan has provided information on the fees of these customized reports as part of the Pricing Proposal.

- C. Describe on-line reporting/management capabilities. Provide sample print-outs from your on-line system. Information on fees should be provided as part of the Price Proposal (IV-G).

On-Line Reporting/ Management Capabilities

Magellan recognizes the need for reporting on a set of core performance indicators to help the State assess the value of our services in meeting industry regulations and to utilize data to manage day-to-day operations. We offer a comprehensive core set of reports to meet those on-line reporting and management capabilities. We have provided sample reporting package in Appendix G. In addition, we have the ability to modify our core reports to ensure that the State's specific needs are being met.

IV-D QUESTIONNAIRE**(sic) 4. Quality Assurance**

- A. Provide a description of your quality management plan, including how it relates to the various departments in your organization. Describe three changes, which have occurred in your system as a result of TQM efforts.

Quality Management Plan

Magellan Behavioral of Michigan's 2000 Quality Improvement Plan and Quality Improvement Program Description are enclosed as Appendix H. The 2000 Quality Improvement and Utilization Management Work Plan outlines a series of specific QI initiatives, objectives, and responsible staff.

Magellan quality management structure addresses all aspects of Magellan's activities. It consists of committee structures with organization-wide provider and stakeholder participation and full time Michigan based Quality Improvement Staff. Responsibility for monitoring and approval of QI activities lies with the Quality Improvement Committee, chaired by Jim Kinville, MBM's President. This body oversees the four QI subcommittees: Utilization Management, Professional Provider Review, Member Advisory Council and Provider Advisory Group.

Ongoing Quality Improvement activities related to utilization management include timeliness of utilization management decisions, over and under utilization, consistency of utilization reports and decisions, ambulatory follow-up and maintenance of community tenure for high risk patients. These activities are overseen by the UM Committee.

Magellan utilizes core performance measures related to access and availability, utilization of services, adherence to clinical practice guidelines, complaint and appeal responsiveness, member and provider satisfaction, network access and density, timeliness of credentialing and recredentialing, timeliness and accuracy of claims processing. In addition, Magellan monitors triage and referral timeliness, documentation and coordination of care, confidentiality and treatment plan turnaround time.

Changes Resulting from TQM Efforts

Organizational changes prompted by Magellan's TQM efforts include the following:

- The results of random after hours audits of work areas indicated that the most frequent location of documents resulting in noncompliance was on individual care manager or customer service representatives desks. Given the importance of confidentiality, in November 1998, keypad locks were installed on doors to care management work areas to prevent non-employees from having access to these areas.

- A field care manager position was established and filled in April of 1999 to provide better coordination with inpatient facilities around discharge planning and aftercare, to work with residential facilities to improve the early detection and management of behavioral health issues in the geriatric population, and to provide outreach services for high risk members.
- Magellan Behavioral of Michigan collaborated with a high volume network provider to develop a new program to meet the needs of members. An Intensive Crisis Treatment program, was implemented in April, 1999. Individuals at risk of inpatient admission/readmission are referred to the program by the care manager, where they are assessed within organizational timeliness standards in accordance with the level of urgency of their situation. A treatment team approach is taken, with family and other member support systems included (with the patient's permission) in the identification of precipitants and design of a treatment plan to allow the individual to function safely within the community. Intensive ambulatory services are provided over a period of days to weeks in accordance with the individualized treatment plan to assist the individual in stabilization and improvement of functioning. Two Borderline Skills groups were also developed to work with individuals with this diagnosis.

B. List accreditation, if any (i.e., NCQA, URAC). Please provide information about your attempts, if any, to collect HEDIS 3.0 results.

Accreditation

AAHCC/URAC Accreditation

Magellan Behavioral of Michigan is currently accredited by the American Accreditation Healthcare Commission (AAHCC, formerly URAC) through 2001.

NCQA Accreditation

MBM received NCQA accreditation as an MBHO on July 19, 2000. Magellan is the industry leader in achieving the first NCQA MBHO certification in Michigan.

HEDIS® Compliance

Magellan has the ability to collect HEDIS® 3.0 data for the State. HEDIS® reports are produced by Magellan's Analytic Services Department, which has staff dedicated to writing the specifications, answering the Base Line Assessment Tool questions, and producing the HEDIS® reports and/or HEDIS® prepared data extracts. We are pleased to note that our specifications and data extracts have successfully passed many NCQA HEDIS® audits. Appendix I includes draft copies of HEDIS® reports, along with a project overview that summarizes the process used to produce the reports and provides an overview of each report.

Our reporting incorporates all of the key measures of current HEDIS® specifications and provides detailed information in line with the parameters as depicted in Figure IV-D.(sic) 4-1.

Figure IV-D.(sic) 4-1: Magellan's Current HEDIS® Specifications

Report Period	Age Groups	Levels of Care
Utilization statistics	Phone system reports	Member satisfaction - QI
Readmission rates	Diagnostic categories	Provider satisfaction - QI
Quality monitors	Complaint and grievance tracking	Authorization and denial tracking.

C. What objective measures/criteria do you use in assessing the quality of care provided to patients?

Assessing Quality of Care

Assessment of the quality of care provided to patients occurs within the context of Magellan's fully integrated Quality Improvement (QI) Program. This program also monitors and evaluates the quality of clinical practice, contributing to improved clinical outcomes. Examples of measures/criteria used to assess the quality of care include:

- **Adverse/Rare Occurrence Indicator Review.** We audit all events considered to pose severe risk to patient safety, well-being, and security, as well as all events that are rare and necessitate review to establish appropriate parameters.
- **Clinical Indicator Studies.** Focused studies are conducted as an integral part of the ongoing QI program to evaluate and monitor clinical services in order to maintain consistent, quality service delivery. For example, a clinical indicator study might include tracking the percent of diagnoses that have been deferred. Each clinical indicator study gives Magellan the opportunity to improve and enhance the delivery of clinical care.
- **Readmissions Review.** Magellan reviews cases of patient readmission to evaluate potential contributing factors and improve coordination of care. Reviews are used to confirm the appropriate execution of procedures, application of utilization criteria, review of alternative options, and implementation of any alternatives for management of the benefit (if alternative options were used).
- **Complaint and Grievance Process.** Any member can register a complaint and/or grievance with Magellan regarding the quality of care or any part of the managed care process, and have it resolved in a thorough and timely fashion. The tracking of these activities and their results are reported to staff and management groups, so that appropriate actions can be taken to address trends or potential problem areas. Service improvement efforts are addressed cross-functionally so that the resolution is more effective. Teams of Magellan staff, providers, and major client groups meet routinely to address operational issues requiring resolution or improvement.

- **Random Audits.** When an event or trend is identified as being outside expected parameters after a review of standardized management reports, random audits are conducted. Magellan devises a specific evaluation and monitoring methodology appropriate to the identified problem area, which typically includes random in-depth review of any part of the clinical process.
- **Inter-Rater Reliability Study.** A treatment plan review should be a thoughtful process that includes careful analysis of the data provided. While it is not possible or even preferable to have reviewers make exactly the same decisions in every situation, it is possible to have comparable clinical decisions if case managers consistently evaluate similar factors. Monthly inter-rater reliability studies are conducted utilizing clinical vignettes. Care Managers and Physician Advisors review clinical vignettes and indicate their responses on an Inter-Rater Reliability Study sheet. The Medical Director's responses on the Inter-Rater Reliability Study sheet serve as the benchmark. The cases and responses are reviewed with the Care Managers and Physician Advisors to review appropriate application of Medical Necessity Criteria.

Compliance with Clinical Practice Guidelines. Magellan has developed Clinical Practice Guidelines for Major Depressive Disorders in Adults, based on the American Psychiatric Association's (APA's) Practice Guidelines for Major Depressive Disorders in Adults, and has adopted the APA's Practice Guidelines for Treatment of Substance Abuse Disorders. At least annually, Magellan conducts a review of network provider compliance with the Clinical Practice Guidelines.

IV-D QUESTIONNAIRE

(sic) 5. Provider Networks, Credentialing and Monitoring

- A. Describe your process for selecting and credentialing participating providers, including a description of professional and malpractice standards, verification of education, experience and license status, law suits and complaints. How often do you perform full credentialing or re-credentialing? Are credentialing criteria that expire annually or semi-annually re-verified?

Magellan conducts a rigorous credentialing process that surpasses standard industry practices, when selecting providers for our network. The special care we take in identifying qualified providers satisfies National Committee on Quality Assurance (NCQA) requirements for health plans, whose programs require NCQA accreditation. In fact, Magellan was awarded full certification as a Credentials Verification Organization (CVO) this year by NCQA, in recognition of the quality of our credentialing program.

Provider Selection

Magellan conducts a thorough process to verify and approve the qualifications of providers interested in joining our network. This process includes:

- Initial screening and application
- Source verification of credentials
- Approving credentials and provider profiling
- Periodic recredentialing

Initial Screening and Application. Interested providers are screened by telephone to determine whether they meet minimum standards for participation. Providers are asked whether they meet minimum criteria for licensure and insurance coverage. Those providers who do so are sent an application packet detailing criteria for selection; responsibilities and agreements involved in joining our network; as well as the formal application that collects information needed to verify professional competence, practice history, and specialty areas.

Figure IV-D.(sic) 5-1 presents Magellan's selection criteria for mental health and substance abuse providers.

**Figure IV-D. (sic) 5-1:
Magellan Provider Credentialing Criteria/Standards**

Provider Type	Credentialing Criteria/Standards
<p>Criteria for All Professionals</p>	<ul style="list-style-type: none"> • Current state licensure. • Current malpractice and liability insurance. <ul style="list-style-type: none"> - Required coverage for physicians: \$1,000,000/occurrence & \$3,000,000 aggregate. - Required coverage for other mental health professionals: \$1,000,000/occurrence and \$1,000,000 aggregate. • Must be vendor-eligible (if applicable). • Membership in a national professional association that subscribes to a professional code of ethics preferred (e.g., APA, AMA, NASW).
<p>Psychiatrists & Other Physicians</p>	<ul style="list-style-type: none"> • Psychiatrists must have completed a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education for Psychiatry or the American Osteopathic Association. • Current and unrestricted state Controlled Dangerous Substances registration (if applicable). • Current and unrestricted Federal Drug Enforcement Administration registration. • American Board of Psychiatry and Neurology or American Board of Osteopathic Medicine certification is preferred. • Other Physicians who are board-certified or board-eligible in a primary care specialty (Internal Medicine, Family Practice, Pediatrics, or Ob-Gyn), and who have more than five years of experience working with substance abuse patients, will be eligible to provide services to chemical dependency patients. American Society of Addiction Medicine certification is preferred.



**Figure IV-D. (sic) 5-1:
Magellan Provider Credentialing Criteria/Standards (continued)**

Provider Type	Credentialing Criteria/Standards
Psychologists	<ul style="list-style-type: none"> • Doctoral degree from an American Psychological Association (APA) accredited program or regionally accredited university or professional school, with a dissertation primarily psychological in nature and with a specialty in Clinical, Counseling or Professional-Scientific Psychology. If this condition is not met, at least one of the following must apply: <ul style="list-style-type: none"> - Council for the National Register of Health Service Professionals in Psychology certified. - American Board of Professional Psychologists Diplomate in Clinical, Counseling, Family Psychology, Neuropsychology, or Health Psychology. - Completion of an APA-accredited Clinical or Counseling respecialization program with completion of an APA-accredited internship. • Psychologists are required to have completed an APA-accredited internship program. If this condition is not met, at least one of the following apply: <ul style="list-style-type: none"> - Council for the National Register of Health Service Professionals in Psychology certified. - American Board of Professional Psychologists Diplomate in Clinical, Counseling, Family Psychology, Neuropsychology or Health Psychology. - Completion of an APA-accredited Clinical or Counseling respecialization program with completion of an APA-accredited internship. • Documentation is provided that demonstrates the equivalency of a one-year supervised internship experience, pre- or post-doctoral, which is comparable to an APA-accredited internship.
Social Workers	<ul style="list-style-type: none"> • A master's or doctoral degree from a school of social work accredited by the Council on Social Work Education. • Be licensed at the highest level in the state for independent practice in the state in which they practice; and • Two years of post-master's clinical social work practice in MH/CD abuse under the supervision of a master's-level social worker (or the equivalent in part-time work, computed at 3,000 direct client contact hours in a period of not less than two years).
Nurses	<ul style="list-style-type: none"> • A master's degree in a human services related field. • A certificate of Clinical Nurse Specialty (CNS) in psychiatric nursing. <p>Two years of post-master's clinical practice in MH/CD abuse work under the supervision of a licensed psychiatrist, psychologist, social worker, or CNS (or the equivalent in part-time work, computed at 3,000 direct client contact hours in a period of not less than two years).</p>

**Figure IV-D. (sic) 5-1:
Magellan Provider Credentialing Criteria/Standards (continued)**

Provider Type	Credentialing Criteria/Standards
Master's Prepared Therapists (Other Than Social Workers or Nurses)	Licensure must be in a Magellan-accepted human services specialty (e.g., Licensed Professional Counselor, Marriage and Family Therapist) Must be vendor-eligible in the state of licensure Requirements for state licensure must include: <ul style="list-style-type: none"> • Successful completion of a written examination covering, at a minimum, state regulations and professional issues, and assessing clinical expertise • A master's degree in a human services-related field of study. • Two years or 3,000 hours of documented post-master's clinical practice in MH/CD under a state-licensed supervisor in the provider's field of specialty. • Primary source verification of items above must be completed by the state licensing board.

Source Verification of Credentials. Upon receipt of a provider's application, all data submitted undergoes verification by Magellan's credentialing staff. Any adverse action cited in legal documents or taken by licensing or professional societies may be investigated by our in-house legal staff according to Magellan legal review requirements. Methods of verifying information are listed below.

- **Regional accreditation**—verified through the Higher Education Directory
- **APA accreditation**—verified through APA published lists or telephone query
- **National Practitioner Data Bank (NPDB) Report**—requested directly by Magellan
- **Verification of Social Work degree accreditation**—directory verification
- **Medicare/Medicaid Sanctioning**—verified through the NPDB report
- **Work History**—review of the submitted curriculum vitae or application information for a 5-year continuous history
- **License**—verified through phone or written query to the state licensing board. A purchased report, this may be in hard copy or electronic format from the licensing board or verification via the Internet

Approving Credentials and Provider Profiling. Once primary source verification is completed, potential providers are asked to provide supplementary information pertaining to clinical specialties, including treatment modalities, client populations served (e.g., children and adolescents, women only), and experience with specific disorders. This information is entered on-line, analyzed, and incorporated into a provider profile.

Through our credentialing process, Magellan verifies both general competence and specific proficiency in treating the range of MHSAs diagnoses and conditions. This enables our care managers to refer every patient to a provider who has the qualifications and expertise to treat that member's particular behavioral health need.

Provider Recredentialing. Magellan credentials providers for a two-year period. Through our automated correspondence system we identify providers whose credentialing is about to expire and request information updates. Providers must resubmit proof of credentials and required documents, such as evidence of licensure and malpractice. The recredentialing process differs from our initial credentialing in that, while initial credentialing is done primarily on the basis of documents submitted to us, recredentialing also incorporates information we accumulate on that provider's actual practice within our network over the preceding two years. In addition, recredentialing determination includes data gathered and recorded on that provider's utilization, employee satisfaction, employee complaints, and quality reviews (including an on-site visit).

B. To what extent does your plan use staff model clinics or capitated provider groups?

Magellan uses staff model clinics in the Lansing, Flint, Saginaw and the Bay City areas only. We do not, at this time, use capitated provider groups. However, if the State wishes, Magellan is willing to explore the usage of capitated provider groups.

Magellan uses staff model clinics primarily for our HMO accounts. However, members of the State Plan have the option of using providers in these clinics, as they are all members of our network.

C. Describe your ongoing provider communication, education and service programs.

Provider Communications

Magellan's corporate resources include a director of provider and employee communications, a manager of provider communications, and a communications specialist. This group works with MBM and the accounts which they serve to ensure consistency and clarity of all provider outreach efforts.

The form, content and frequency of provider communications is dictated by necessity. We provide timely, clear communications on all matters that impact providers. We have quarterly provider newsletter and ongoing Internet communication through our website.

Magellan's care managers utilize a variety of methods to communicate with providers, depending upon the nature of the communication and the technology available to the provider. As continued treatment is authorized, certification information is entered on-line into the patient care tracking system. Both providers and patients are notified by mail of authorization decisions, along with information about Magellan's appeals process.

Mail, fax and telephone are most frequently utilized to communicate with providers regarding eligibility, claims, and treatment authorizations. We recognize, however, that these methods take time and become unwieldy when providers are dealing with multiple managed care entities. Therefore, Magellan has developed a website that will allow providers to access updated information in a more timely manner. Information which will be housed on the website includes: Magellan's Medical Necessity Criteria, Clinical Practice Guidelines and the Provider Handbook. Providers can also access the consumer content on the website.

Provider Education and Service

Magellan provides education and training to network providers on an ongoing basis. The subjects of such training are driven by results of various performance measures, as well as by input from the providers themselves. The training is conducted in various forums, including provider forums and teleconferences. In December 1999, MBM hosted a Provider Forum. Topics included provider participation in the QI program, current prevention initiatives, and Magellan Behavioral Health's medical necessity criteria. The Forum included adequate time for provider questions and answers.

Magellan has developed practice protocols for all providers. They are distributed to providers by mail or providers can access them at www.magellanassist.com, our provider education and communication website. In addition to the practice protocols, Magellan uses the following vehicles to review the performance of network providers.

Provider Profiles. We can generate reports that depict a subset of profiled performance data that is shared with large-volume providers. Information, presented in a simplified format, shows both provider findings and network results. This allows the provider to compare his/her own performance with that of practitioners with similar practices in the community. Dimensions of provider performance shown on these reports include: patient satisfaction, access to care, appropriateness of care, resource efficiency, and clinical effectiveness. The profile is a major vehicle for provider education.

Site Visits/Chart Audits. Following any provider site visit or audit of patient charts, a summary of findings and recommended improvements and/or corrective actions is shared with the provider. For high volume providers and facilities, these results are presented in person to encourage further discussion and strengthen the partner relationship.

Provider Advisory Group. The Provider Advisory Group (PAG) has been established to obtain provider input into Magellan Behavioral of Michigan operations. Figure IV-D.(sic) 5-2 presents the membership of the PAG .

Figure IV-D. (sic) 5-2: Provider Advisor Group Membership

Name	Degree	Affiliation/Title
James E. Kinville	MA, LLP	Chairperson, RSC President, Magellan Behavioral of Michigan
Fred Wigen		President, Kairos Health Care
Pat Moallemian	MD	Director of Senior Services, Ingham Regional Medical Center
Troy Wendell	RN	Clinical Manager, Sparrow Behavioral Health
Rick Copen	PhD	Rick Copen, PhD
Diane Daley	MSW	President, Daley Life Center
Tom Dryer		Insight Recovery Center
Richard Kneip	PhD	Oakland Psychological
Margery W. Trower	MSW	Staff Practice Manager, Magellan Behavioral of Michigan
Hilton Thomas	PhD	Professional Psych and Rehab
Beverly Fauman	MD	Provider, Magellan Behavioral of Michigan

Topics of recent teleconferences included late-life depression, ADD, delirium in the elderly, and suicidal ideation and content.

D. Describe your ongoing provider monitoring programs, including policy and quality compliance, utilization profiling, and dispute resolution. If you do actively profile network providers, is the system paper-based, or on-line? What percentages of all providers have been profiled? How do you plan to use the information?

Magellan has developed a tiered approach to provider monitoring that is based on the providers' volume of members treated as well as practice setting. Our monitoring includes both on-line and paper-based information.

Magellan collects utilization, complaint and grievance and adverse incident information on all providers, regardless of the volume of members treated. For all providers and or provider groups or who see a high to moderate percentage of members on an in-network self referred basis, we conduct a more extensive profiling process. The rationale for differentiating this group is our ability to gather meaningful data. NCQA no longer requires site visits for all providers. However, Magellan continues to conduct site visits with high volume providers. Magellan has profiled 7 percent of the providers which will provide service to State members.

Criteria that are monitored for providers include:

- Member Satisfaction
- Patient-Centric Data, such as Patient Session Rating Scales
- Complaint and Grievance Data
- Quality Improvement Indicators, including Chart Audits
- Percentage of Requests for Transfer to Another Provider
- Site Visits

- Input from Care Management Staff
- Adverse Incidents
- Re-admissions of "Routine" Members to Higher Levels of Care
- Clinical Resource Management
- Percentage of members seen utilizing full benefit
- Under- and over-utilization of services
- Appointment Availability
- Profiling is used for oversight of practice patterns

Quality Control

To ensure quality, Magellan has developed a series of measures of internal processes, which meet the requirements of various regulatory bodies, as well as our own high standards for performance. These measures involve:

- **Provider credentialing**—Magellan's credentialing process includes primary source verification to support our stringent credentialing criteria.
- **Audits**—Internally, we conduct monthly audits for toll-free line counselors. Clinical record audits are conducted for high-volume providers and high-risk providers every other year at time of recredentialing. On-site provider office assessments are also conducted.
- **Outcome studies**—Studies allow Magellan to design and implement training programs for network providers and our own care managers.
- **Satisfaction surveys**—Magellan not only surveys the members that use our services, but also the customers that purchase our services, and the providers who deliver the services. This important feedback aids our continuous quality improvement process.
- **Complaint resolution**—Our formal complaint resolution program involves every department and employee within Magellan. Complaints can be generated by internal or external customers, and are documented and tracked through resolution. Our pledge is to resolve complaints within ten business days.

E. Describe the qualifications of your staff members responsible for credentialing and monitoring providers.

Paul Namel, Network Manager, and his local provider relations staff are located in the Farmington Hills, MI office. They are responsible for provider mentoring and education in Michigan. Mr. Namel has over 30 years of experience in the health care industry and has provided network development for the Great Lakes Health Plan and Blue Cross Blue Shield of Michigan. He has a BS in Business Administration and has completed graduate course work in contract law and managed care disability. The Provider Relations Staff also

analyzes data captured in all monitoring and oversight activities. Our credentialing is headed by Lisa Slater Williams, a masters prepared administrator. Her staff include masters and bachelor level person with previous credentialing experience.

Qualifications of Staff

The credentialing staff is required to have a minimum of two years experience in the health care industry and it is preferred that they have a bachelors degree.

- F. Provide provider departicipation rates for the last three years, with a breakdown by reasons for departicipation.

Figure IV-D.(sic) 5-3 contains data on network turnover for the past three years:

Figure IV-D. (sic) 5-3: Provider Turnover

	Percentage of Providers Terminated
1997	5.2
1998	5.8
1999	4.9

Voluntary terminations were for the following reasons:

- Provider retired
- Provider died
- Provider moved out of the area
- Provider left the group

Involuntary turnover was for the following reasons:

- Quality issues
- License sanction issues

- G. What portion of current services are provided in-network, both nationally, and for Michigan, in particular (describe separately for professional vs. facility services, by type of facility)?

Nationally 89 percent of all services are performed in-network; in Michigan, 99 percent of services are performed in-network.

IV-D QUESTIONNAIRE

6. Provider Network Analysis

The State is requesting bids for the best fit that offers competitive pricing while still meeting the access standards defined in B. below.

- A. [NETWORK ACCESS DATA] Complete a network Geo-analysis for your proposed network based upon minimum access standards defined in this RFP and the member residence zip code data provided. Separate analyses should be provided for Actives and Retirees.

The complete network analysis reports for actives and retirees are included in Appendix J.

- B. [ACCESS NOT GUARANTEED] Identify the 5-digit zip codes where the mileage access standards (i.e., at least 1 participating provider within 5 mi urban, 10 mi suburban, and 20 mi rural) cannot be guaranteed, separately for Actives and Retirees. Report data using the following format in a Microsoft Excel file on PC-diskette:

State	City	5-Digit Zip Code	Number of Participants	Distance to Nearest Provider
Total				

A hard copy and electronic file which contains the Access not guaranteed report is included in Appendix K.

- C. [ACHIEVING ACCESS TARGET] For 5-digit zip codes with available providers that do not meet the required access standard, describe the procedures and timing required to increase network participation in order to achieve the requested standard. Describe the process which allows the State and its participants to recommend providers for addition to the network.

Magellan's primary objective in network development is to provide continuity for the State's members and to minimize any disruption in service. In addition, we wish to enhance the network currently available to the State's membership. We will conduct a disruption analysis of our network and that of the existing vendor and aggressively recruit providers, facilities and programs that currently serve this population. In areas where the access is less than desirable, such as those indicated in question B above, Magellan will further develop our network.

Magellan has conducted a preliminary network development plan. In the cities/counties where access is less than desirable, we have researched available facilities, programs and professional providers. Following is a city/county breakdown with our initial network findings.



Sault Sainte Marie and Brimley are located in Chippewa County where there are over 3,064 members of the State plan. We will work with Eastern Upper Peninsula Mental Health Board and Chippewa Ware Memorial Hospital to finalize network status and have identified a Psychiatrist, Psychologist and a Masters Prepared therapist to include in the network.

Coldwater and Cool Water are located in Branch County where there are 2,288 members of the State plan. We will work with The Community Health Care Center of Branch County and Coldwater Community Hospital. In addition, we have identified a Psychiatrist, a Psychologist and a Masters Prepared Therapist.

In both Mackinac and Luce Counties there are close to 1,400 members. Like the other areas in the Upper Peninsula, resources are sparse. In both Luce and Mackinac, there are no acute hospitals that provide psychiatric services. Members currently go to Chippewa Ware Memorial Hospital in Emmet County or Marquette General Hospital. We have not identified any providers in these counties but will continue to explore provider options. There are Community Mental Health resources in both counties.

There are 988 members in Manistee, which is located in Manistee County. This city is 40 miles southeast of Traverse City; in which Munson Hospital has 26 psychiatric beds. We have located 1 Psychologist and 3 Masters prepared therapists in this county. In addition, there is a CMC.

In Wexford County, where Cadillac is located, there are 944 State members. This city is also within 40 miles of the psychiatric unit at Munson Hospital in Traverse City. There is a CMC in Wexford County and we have located 1 psychologist and 3 masters prepared therapists.

Lanse is located in Baraga County where there are 868 state members. Residents generally use Marquette General Hospital, located 20 miles East of the County. We have identified a Masters Prepared therapist and there is a CMC in this county.

Hillsdale is located in Hillsdale County. There are 800 members in this city. We have located three masters prepared therapists and have spoken to residents who say they are comfortable with using resources in Adrian, Jackson and Branch Counties where Magellan has network providers.

Ludington is in Mason County where there are 756 members. Ludington Community Hospital has psychiatric beds, providers and therapists. They are willing to discuss a facility agreement and would consider endorsing Magellan to their staff psychiatrists (two) and therapists. CMC services also are available. An additional psychologist has been identified in this county.

Both Roscommon and Houghton Lake are located in Roscommon County where there are 602 members. Participants have access to the psychiatric units at Alpena General Hospital and Mercy Cadillac, both of whom have expressed support of Magellan's contracting efforts for the State of Michigan members. We have located 2 psychologists and 1 masters prepared therapist in Roscommon County and will also approach the CMH.

Grayling is located in Crawford County where there are 580 members. St. Joseph Mercy has a psychiatric unit and staff in private practice. We also have located 3 masters prepared therapists.

Cheboygan in is Cheboygan County where there are 546 members. There are no psychiatric beds in the hospital in this county. There is a CMC and we have identified 4 masters prepared therapists. Members in the northern part of the county can utilize Emmet County Hospital and members in the southeastern part of the county can use Alpena General.

Schoolcraft County, which is in the Upper Peninsula of Michigan, has 471 members. There are outpatient providers at Catholic Social Services and the CMC.

Hastings is located in Barry County. There are 456 members in this city. We have located a psychologist and masters prepared therapist in Hastings. In addition, we have a large network in Grand Rapids, Lansing, Battle Creek and Kalamazoo; locations now accessed by these members.

Osceola County has 429 members. The nearest hospital with psychiatric access is Mercy Cadillac, 40 miles north of the county line. There is a CMH in this county.

Harbor Springs and Petoskey are located in Emmett County where there are 398 members. We have identified 1 psychiatrist, 3 psychologists and 8 masters prepared therapists. There also is a psychiatric unit in the general hospital.

Houghton and Hancock are located on Houghton County where there are 372 members. The closest hospital for inpatient services is Marquette General, which is 50-60 miles away. We have identified 1 psychiatrist and 6 masters prepared therapists as well as the CMC in this county.

Centerville is in St Joseph County. There are 363 members. Kalamazoo, which is 20 miles away where there is excellent network access for inpatient and outpatient services. In addition, we have located a psychologist and masters prepared therapist in this county.

Standish is in Arenac County where there are 351 members. The nearest hospital with psychiatric beds is in Midland/Bay City, 30 miles away. There is a CMC in this county and we have located a masters prepared therapist.

Sandusky is in Sanilac County where there are 280 members. In the adjacent counties of Huron and Tuscola there are psychiatric facilities and a good number of providers. We have identified one psychiatrist and 1 masters prepared therapist in this county.

Tecumseh and Adrian are in Lenawee County where there are 278 members. We have identified 9 psychiatrists, 8 psychologists and 7 masters prepared therapists willing to contract with Magellan.

In Missaukee County, there are 273 members. The nearest facility is Mercy Cadillac, 40 miles away. There is a CMC in this county.

In Kalkaska, where there are 256 members, there are no psychiatric beds. There is a CMC.

Charlevoix County has 255 members. Currently members access service in Traverse City and Petoskey. There is a CMH in this county.

Timing

We expect the network buildout to be completed within 90 days. As we are completing credentialing, we will authorize services requested by members at the UCR rate. In addition, following contract award, we will operationalize a provider nomination 800# Line so that participants as well the State can nominate network providers whom we will then recruit and grant ad hoc privileges as credentialing is being completed. Magellan works in several states with AWP laws and builds this provision into our network development and maintenance.

D. [NETWORK DISTRIBUTION] For the proposed network, provide the following information based on your geo-analysis results, separately for Actives and Retirees, and separately by professional (psychiatrists and psychologists) and facilities (psychiatric hospitals, residential SA centers, partial/day/night, and halfway houses):

Type of Area (zip code based)	Access Standard: 2 Profesionals	Access Standard: 1 Facility	Number of Particip. Providers	% of Participants within Minimum Access Standard
Urban	10 miles	10 miles		
Suburban	15 miles	20 miles		
Rural	20 miles	40 miles		
TOTAL				

The network distribution report is included in Appendix L.

E. [DIRECTORY] Include a copy of the proposed network directory.

The proposed network directory is included in Appendix M.

F. [SAMPLE CONTRACT] Supply a sample copy of your provider contract.

Sample provider contracts (facility and professional provider) are included in Appendix N.

G. [NETWORK COMPOSITION] For each county in the State of Michigan, and by state outside Michigan, show the number of each of the following for your current participating providers:

- Psychiatrists (MD/DO) Board certified/eligible
- Psychologists (Ph.D., Psy.D., Ed.D.)
- Licensed clinical social workers (LCSW)
- Masters-prepared clinicians (MSW)
- Other professional providers
- Acute Care Hospitals
- Psychiatric Hospitals
- Residential SA Treatment Centers
- Partial, day/night, halfway house, etc. facilities

Network composition reports are included in Appendix O.



IV-D QUESTIONNAIRE

7. Performance Standards and Guarantees

Define the guaranteed terms of the performance standards outlined below.

Performance Standards and Guarantees	Guarantee
1. Maximum Annual Increase in Avg. Cost per Service: a. Max. increase in Avg. Cost/Svc, FY2001 to FY2002. b. Max. increase in Avg. Cost/Svc, FY2002 to FY2003.	_____ % _____ %
2. Provider Network Access; for the proposed network: a. % of urban participants in network svc. area b. % of suburban participants in svc. area c. % of rural participants in svc. area	_____ % _____ % _____ %
3. Network Management a. % of particip. Providers audited on-site per year b. % of claims processed that will be in-network	_____ % _____ %
4. Eligibility Processing (expected standards shown) a. Time to update eligibility files with State data b. % of ID cards created & distributed within 10 business days, with an accuracy rate of 99%+. c. % of ID cards created & distributed within 15 business days, with an accuracy rate of 99%+.	2 days 85% 100%
5. Claims Processing Time (expected standards shown) a. % of claims approved or responded to within 10 business days b. % of claims approved or responded to within 20 business days	85% 99%
6. Claims Processing Accuracy a. Financial Payment Accuracy b. Payment Incidence Accuracy c. Claim Processing Accuracy	_____ % _____ % _____ %
7. Customer Service a. % of calls that will be answered within: - 15 seconds - 20 seconds - 30 seconds b. Avg. time to answer customer service calls c. % of calls abandoned d. % of calls blocked e. % of written inquiries responded to within 5 business days f. % of written inquiries responded to within 10 business days	_____ % _____ % _____ % _____ sec. _____ % _____ % 95% 100%
8. Participant Satisfaction Survey % of participants satisfied with MHSA program per survey results (Describe type of survey)	_____ %



<p>9. Reporting (expected standards shown): a. Monthly reports, due following close of month b. Quarterly reports, due following close of quarter c. Annual report & file, due following close of year</p>	<p>30 days 60 days 90 days</p>
<p>10. Account Service a. % of calls returned by account service representative within 12-24 hours of receipt b. % of calls resolved within 24 hours of receipt c. No. of days for a response to a written inquiry</p>	<p>_____% _____% ____ days</p>
<p>11. Other Service Performance Guarantees Indicate your willingness to offer other service performance guarantees to satisfy the specific performance objectives of this organization, including (but not limited to) the following: a. Personalized Provider Directory Feed b. Improved network usage c. Data coding accuracy</p>	
<p>12. Implementation a. Terms of guarantee to ensure that all services are implemented as proposed within specified timeframe b. Conditions or Exceptions</p>	

Define the penalty to be assessed for each performance guarantee if the proposed standard is not achieved. Define the penalty as a percent of administration fees and estimate the total dollar value equivalent of the penalty. State your willingness to permit this organization to redistribute the total penalty and explain any conditions.

The proposed performance guaranteed are included on the the last page of this section.

Service Performance Guarantee	Penalty Amount (dollars or % of admin.fees)	Penalty Description • Explanation of Conditions • Basis for Measuring • Freq. Of Measurement • Freq. Of Penalty Reconciliation • Subject to Aggregate Limit?
1. Max. Annual Increases		
2. Provider Network Access		
3. Network Management		
4. Eligibility Processing		
5. Claims Processing Time		
6. Claims Processing Accuracy		
7. Customer Service		
8. Participant Satisfaction		
9. Reporting		
10.Account Service		
11.Other Service Performance Guarantees		
12.Implementation		
13.Indicate AGGREGATE LIMIT		

Magellan's proposed performance standards are included on the following page.

IV-E BIDDER'S AUTHORIZED EXPEDITOR

Include the name and telephone number of person(s) in your organization authorized to expedite any proposed Contract with the State.

Barbara Cahn, Ph.D., is the person authorized to expedite any proposed contract with the State. She can be reached at 1.800.458.2740, extension 1270 or 410.953.2403.

RESUMES

JAMES E. KINVILLE, MA, LLP.
President, Magellan Behavioral of Michigan

QUALIFICATIONS SUMMARY:

Mr. James E. Kinville, president of Magellan's regional operation in Michigan, has more than 14 years of experience in behavioral health care. At Magellan Behavioral of Michigan (MBM), he is responsible for managing a budget of \$15 million, directing a staff of 70 employees, and overseeing care delivery to 2.7 million lives. He is responsible for clinical administration, operations, finance, quality management, marketing, and medical direction. Prior to joining Magellan, he served in several senior positions at Value Behavioral Health in Virginia, including vice president of corporate provider relations, director of EAP and provider services, and clinical specialist for provider relations. He also worked as a primary therapist for recovery programs at Oxford Institute in Michigan. Mr. Kinville is a Limited Licensed Psychologist in the State of Michigan and is a member of the Michigan Psychological Association and the Employee Assistance Professionals Association. He received an MA in clinical psychology and substance abuse studies from the University of Detroit, Mercy, and a BS in psychology and behavioral science from Grand Valley State University in Michigan. Mr. Kinville has direct responsibility for the Blue Care Network and Blue Cross Blue Shield of Michigan accounts.

EXPERIENCE:

1996 to Present

President, Magellan Behavioral of Michigan, Farmington Hills, MI, formerly Green Spring Health Services, Inc.

Manages behavioral health managed care products for 2.7 million lives. Products include HMO risk and indemnity ASO. Supervises 70 employees and is responsible for directing and managing clinical administration, operations, finance, and marketing. Supervises development of management and quality assurance programs. Establishes criteria for measuring and assessing success/performance of each operation and ensures corrective action is taken when necessary. Develops effective relationships with member and provider communities.

1988 to 1996

Vice President, Corporate Provider Relations, Value Behavioral Health, Falls Church, VA

Managed a staff of 10 employees and had responsibility for a budget of \$2 million. Developed corporate policies and procedures and oversaw credentialing and recredentialing, provider contracting, provider database design, and provider disenrollments. Developed clinical care groups and supervised the development of a credentialing/rec credentialing database.

1991 to 1994

Director, EAP/Provider Services

Supervised 12 employees and was responsible for credentialing and recredentialing a 3,000-provider network. Managed provider network development, including EAP relations and provider contracting and developed a quality improvement program for provider credentialing and contracting. Served as liaison to EAP clients. Conducted numerous provider education and training programs.

1989 to 1991

Clinical Specialist for Provider Relations

Responsible for on-site reviews and provider network development, contracting, credentialing, and recredentialing. Performed telephonic case management and triage. Conducted provider seminars on managed care.

1985 to 1989

*Primary Therapist/Residential Therapist for Health
Professional Recovery Program, Oxford Institute, Oxford,
Michigan*

Conducted psychological assessments; coordinated seminars; gave lectures; conducted therapy for individuals, groups, and families. Managed a staff of three clinicians. Assisted in the development of policies and procedures. Interfaced with the state licensing board. Conducted numerous lectures to hospitals, nursing associations, and licensing boards on chemical dependency.

EDUCATION:

MA, Clinical Psychology and Substance Abuse Studies, University of Detroit, Mercy, 1986

BS, Psychology and Behavioral Science, Grand Valley State University, Michigan, 1983

LICENSURE/CERTIFICATION:

Licensed Psychologist, State of Michigan

MEMBERSHIPS/AFFILIATIONS:

Michigan Psychological Association

Employee Assistance Professionals Association

PUBLICATIONS/PRESENTATIONS:

None.

