

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

July 28, 2008

CHANGE NOTICE NO. 12
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Cscherer@qlhp.com	TELEPHONE (248) 331-4284 Chris Scherer
	BUYER/CA (517) 241-4225 Kevin Dunn
	Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH
CONTRACT PERIOD: From: October 1, 2004 To: September 30, 2009	
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 October 1, 2008, this Contract is hereby INCREASED by \$215,623,385.71, and the Contract is renewed through September 30, 2009. Furthermore, the attached changes in language are incorporated into this Contract. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request and DMB/Purchasing Operations' approval.

REVISED CURRENT AUTHORIZED SPEND LIMIT: \$883,499,355.04

FOR THE VENDOR:

Great Lakes Health Plan Inc.

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature
Elise A. Lancaster

 Name
Director, Purchasing Operations

 Title

 Date

**Contract Changes for Fiscal Year 2009
July 18, 2008**

Section I

Contract Change #1: I-W Delegation

In order to clarify that all notification requirements that apply to administrative subcontractors, with the exception of the timeline for notification, also apply to notifying DCH of a new Health Benefit manager, the following information from Section I-F is added to section I-W. The term "subcontractor" is changed to "Health Benefit Manager" to clarify the intent.

The contractor must notify the state and identify the ~~subcontractor~~**Health Benefit Manager(s)**, including firm name and address, contact person, complete description of work to be subcontracted **covered by the contract with the Health Benefit Manager, and descriptive information concerning subcontractorHealth Benefit Manager's organizational abilities.** Use of a ~~subcontractor~~**Health Benefit Manager** without ~~notice to~~ **prior approval** by DCH may be cause for termination of the Contract.

In accordance with 42 CFR 434.6(b), all subcontracts with a **Health Benefit Manager** entered into by the Contractor must be in writing and fulfill the requirements of 42 CFR 434.6(a) that are appropriate to the service or activity delegated under the subcontract. All subcontracts with a **Health Benefit Manager** must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All such subcontracts must fulfill the requirements of this Contract that are appropriate to the services or activities delegated under the subcontract. For each portion of the proposed services to be arranged for and administered by a ~~subcontractor~~**Health Benefit Manager**, the proposal must include: (1) the identification of the functions to be performed by the ~~subcontractor~~**Health Benefit Manager**, and (2) the ~~subcontractor~~**Health Benefit Manager's** related qualifications and experience.

All employment agreements, provider contracts, or other arrangements, by which the Contractor intends to deliver services required under this Contract, whether or not characterized as a subcontract or **contract with a Health Benefit Manager**, shall be subject to review and approval by the State and must meet all other requirements of this paragraph appropriate to the service or activity delegated under the agreement.

The Contractor shall furnish information to the State as to the amount of the subcontract **with the Health Benefit Manager**, the qualifications of the ~~subcontractor~~**Health Benefit Manager** for guaranteeing performance, and any other data that may be required by the State. All subcontracts with **Health Benefit Managers** held by the Contractor shall be made available on request for inspection and examination by appropriate State officials, and such relationships must meet with the approval of the State.

The Contractor shall furnish information to the State necessary to administer all requirements of the Contract. The State shall give Contractors at least 30 days notice before requiring new information.

Rationale: Last year, DMB allowed DCH to modify Section I of the contract to distinguish between administrative subcontracts (covered under Section I-F) and subcontracts with Health Benefit Managers (covered under Section I-W). However, DCH did not specifically include the notification requirements for subcontractors into I-W. This contract change rectifies the oversight and ensures the MHPs provide sufficient notification for Health Benefit Manager subcontracts.

Section II

Contract Change #2: Pregnant Women

Modify Section II-D-1 and Section II-D-2 of the contract (Medicaid Eligibility and CHCP Enrollment) to indicate that the pregnant women population is changed from a voluntary population to a mandatory population. Specifically, in Section II-D-1 of the contract, the final bullet is changed to read as follows:

- Pregnant women ~~residing in a county listed in Appendix 6~~

Additionally, in Section II-D-2 of the contract, the final bullet is removed. Appendix 6 is removed since mandatory enrollment of pregnant women is no longer county specific.

Rationale: Michigan Medicaid is enacting policy changes to allow the mandatory enrollment of pregnant women into MHPs.

Contract Change #3 – Auto-Assignment Algorithm

Modify Section II-F-2, Initial Enrollment, to provide information concerning the elements and formula used for the automatic enrollment algorithm. Specifically, the second paragraph of Section II-F-2 is changed to read as follows:

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

Rationale: The additional information regarding the algorithm is provided at the request of the plans. DCH will continue to distribute detailed explanation of the algorithm calculation each quarter with the algorithm results.

Contract Change #4 Transportation

Modify Section II-H-11 to further clarify the required transportation benefit. Specifically, Section II-H-11 is revised to read as follows:

When necessary, the Contractor must provide non-emergency transportation, including travel expenses, to authorized, covered services. **Contractors must provide, at a minimum, the services outlined in the DCH guidelines for the provision of non-emergency transportation including the provision of t**~~Travel expenses, include meals, and lodging as directed under DHS guidelines for the provision of lodging and meals.~~ **Contractors must also utilize DHS guidelines for the determination of necessity evaluation of a member's request for medical transportation to maximize use of existing community resources.** ~~and the provision of non-emergency transportation.~~ DCH will obtain and review Contractor's non-emergency transportation policies, procedures, and utilization information, upon request, to ensure this requirement is met.

Contractors must provide medical transportation to receive any service covered by this contract, including, but not limited to the following:

- **Chronic and ongoing treatment**
- **Prescriptions**
- **Medical supplies**
- **Onetime, occasional and ongoing visits for medical care**

The transportation benefit does not include transportation to services that are not covered under this contract such as transportation to WIC services, MIHP services, dental office services, CMHSP services or transportation to substance abuse services.

Rationale: The purpose of the contract change is to provide further guidelines and clarification on non-emergency transportation to ensure consistent (minimum standards) for coverage among MHPs and FFS. MHPs may choose to offer enhanced transportation benefits over the minimum standards.

Contract Change #5 Program Integrity

Modify four sections of the contract that reference program integrity to provide additional clarification on program integrity requirements. Specifically, Section II-B-3, Section II-I-9, Section II-L-3, and Section II-L-4, are revised as indicated.

II-B-3. Contractor Accountability, 8th bullet is revised to read as follows:

- Providing procedures to ensure program integrity through the detection, and prevention, **education, and reporting** of fraud and abuse and cooperate with DCH and the Department of Attorney General as necessary.

II-I-9 Compliance with False Claims Act, modify the final two bullets to read as indicated below. Deletion of the language in the first bullet below is necessary to correct an oversight in the previous contract.

- The written policies must also be adopted by the Contractor's contractors or agents A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. ~~Contractors or agents that meet or surpass the monetary threshold are subject to the requirements in this Section.~~
- If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees **regarding detection and prevention of fraud and abuse** including an explanation **of the false claims acts** and of the rights of employees to be protected as whistleblowers.

II-L-3 Administrative Requirements, modify the third bullet to read as follows:

- Policies and procedures for **providing education to employees, providers and members** for identifying, addressing, and reporting instances of fraud and abuse;

II-L-4 Program Integrity, modify the first paragraph under the address to read as follows:

The Contractor must report all **(employee, providers and members)** suspected fraud and/or abuse that warrant investigation to the DCH Program Investigation Section.

Rationale: During the annual onsite visits, it became clear that certain contract requirements were not entirely consistent with the site visit criteria. The purpose of the contract change is to provide further written standards for the MHPs to alleviate the inconsistency.

Contract Change #6: Maternity Case Rates

Modify Section II-L-5 (Management Information System) to provide updates to requirements concerning Maternity Case Rate payment requests. Specifically the last part of subsection of Section II-L-5 is revised to read as follows

The Contractor is required to utilize the Department's Automated Contact Tracking System (~~currently, Beneficiary and Provider Contact Tracking System, BPCTS~~) to submit the following requests:

- Disenrollment requests for out of area members who still appear in the wrong county on the Contractor's enrollment file
- Request for newborn enrollment for out of state births or births for which DCH does not notify the Contractor of the newborn's enrollment within 2 months of the birth
- Maternity Case Rate Invoice Generation request for ~~out-of-state births or~~ births for which ~~DCH does not notify the Contractor of the newborn's enrollment~~ **the Contractor has not received an MCR payment** within ~~2~~ **3** months of the birth
- Other administrative requests jointly developed by DCH and Michigan Association of Health Plans during the term of the Contract

Rationale: Changes in the newborn processing automated system require DCH to extend the timeline before which MHPs are allowed to submit requests for payment of the Maternity Case Rate. Additionally, the contract change updates the language with respect to DCH's new Medicaid Management Information System -- CHAMPS.

Contract Change #7 Marketing

Modify Section II-R to clarify guidelines for marketing material, as well as allow use of health plan decals in provider offices. The second paragraph of Section II-R is revised to read as follows:

Direct marketing to individual beneficiaries not enrolled with the Contractor is prohibited. ~~If a beneficiary initiates a contact,~~ **For purposes of oral or written marketing material, as well as contact initiated by the beneficiary,** the Contractor must adhere to the following guidelines:

- The Contractor may only provide factual information about the Contractor's services and contracted providers.
- If the beneficiary requests information about services, the Contractor must inform the beneficiary that all MHPs are required **at a minimum** to provide the same services as the Medicaid fee-for-service program.
- The Contractor may not make comparisons with other MHPs.
- The Contractor may not discuss enrollment, disenrollment, or Medicaid Eligibility; the Contractor must refer all such inquiries to the State's enrollment broker.

Additionally, Section II-R-2 is changed to read as follows:

2. Prohibited Marketing Locations/Practices that Target Individual Beneficiaries:
 - Local DHS offices
 - Provider offices, clinics, including but not limited to, WIC clinics, **with the exception of window decals that have been approved by DCH.**
 - Hospitals

- Check cashing establishments
- Door-to-door marketing
- Telemarketing
- Direct mail targeting individual Medicaid Beneficiaries not currently enrolled in the Contractor's plan

The prohibition of marketing in provider offices includes, but is not limited to, written materials distributed in the providers' office. The Contractor may not assist providers in developing marketing materials designed to induce beneficiaries to enroll or to remain enrolled with the Contractor or not disenroll from another Contractor. **Contractors may provide decals to participating providers which can include the health plan name and logo. These decals may be displayed in the provider office to show participation with the health plan. All decals must be approved by DCH prior to distribution to providers.**

Rationale: All other commercial and Medicare carriers are allowed to provide decals indicating provider participation. DCH has agreed to allow MHPs to supply decals with the health plan logo that may be posted in the provider office window. Additionally, DCH revised the language regarding marketing content to assure consistent implementation of marketing guidelines and oversight.

Contract Change #8 Provider Directory

Modify Section II-S-2 (Member Handbook) to allow MHPs to remove office hour information from the provider directory. Specifically, the second bullet under the provider directory requirements in Section II-S-3 is revised as follows.

- For PCP listings, the following information must be provided: Provider name, address, telephone number, any hospital affiliation, days and hours of operation, whether the provider is accepting new patients, and languages spoken. **Once the Contractor achieves and maintains full compliance with completing office hour information on the 4275 provider file, the Contractor may remove days and hours of operation from the PCP listing in the provider directory.**

Rationale: Office hours change frequently which makes the provider directory quickly out-of-date and not useful to members. Rather, MHPs provide this information on the plans' websites and are required to submit the information whether the provider has late evening or weekend office hours in the electronic provider file submitted to DCH.

Contract Change #9: Infertility

Modify Section II-G-I and II-G-4 to clarify MHP's responsibility for the coverage of infertility services. Specifically, in Section II-G-1, the "Family Planning Services" bullet is revised as follows:

- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis).

Additionally, the following bullet is inserted into II-G-4:

- **Medicaid does not cover services for treatment of infertility.**

Rationale: Medicaid policy states the screening for infertility is a covered service while treatment for infertility is not a covered service. However, this contract change is needed to clearly delineate the infertility services covered, and not covered, by the MHP contract.

Contract Change #10: Third Party Liability

Modify Section II-Q (Third Party Liability) to explicitly state MHPs' rights regarding collections for third party liability. Specifically, the second paragraph of Section II-Q is revised to read as follows:

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a member's health care coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. The Contractor may retain all such collections. If TPL resources are available, the Contractor is not required to pay the provider first and then recover money from the third party; **however, the Contractor may elect to "pay and chase". Contractors may research, identify and recover all sources of third party funds based on industry standards.** ~~but~~ The Contractor should follow Medicaid Policy regarding TPL. The Contractor must report third party collections in its encounter data submission and in aggregate as required by DCH.

Rationale: Like the State Medicaid program, MHPs must operate as the "payer of last resort." However, some providers have construed the Medicaid provider manual and the MHP contract narrowly as not allowing MHPs the same rights to "pay and chase" all sources of third party funds as is held by Medicaid fee-for-service. The contract change removes this barrier to MHPs' ability to effectively managed third party funds.

Contract Change #11: Service Area Expansion

Modify Section II-C to clarify that service area expansions will be based on the need for additional capacity in a county.

DCH may consider Contractors' requests for service area expansion during the term of the Contract. Approval of service area expansion requests will be at the sole discretion of the State. ~~The state may consider certain factors including, but not limited to, the need for additional capacity, Contractor performance, Contractor fiscal status, and Contractor provider network, and will be contingent upon the need for additional capacity in the counties proposed under the expansion request.~~

Rationale: Over the past several months, DCH has approved several service area expansions based on factors other than additional capacity. In order to stabilize service area status, DCH will require that additional capacity is needed in a county before allowing expansions into the county.

Contract Change #12: Therapies – clarification of coverage requirements

Modify Section II-G to clarify the services covered under the therapy benefit in the MHP contract. Specifically, DCH proposes the following revisions to Sections II-G-1 and II-G-3 of the contract, respectively:

1. Services Included

- Therapies (speech, language, physical, occupational) **excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program providers or Intermediate School Districts.**

3. Services Covered Outside of the Contract

- Services, **including therapies (speech, language, physical, occupational)**, provided to persons with developmental disabilities which are billed through Community Mental Health Services Program providers **or Intermediate School Districts.**

Rationale: Review of decisions made on Fair Hearing cases indicates that the language regarding the therapies covered by MHPs is not clear. Specifically, the revisions are intended to separate therapy coverage responsibilities of the MHPs and therapy coverage responsibilities of CMHSPs and intermediate school districts.

Contract Change #13: Maternal Infant Health Services (MIHP) carve out

With the mandatory enrollment of pregnant women into MHPs, DCH has agreed to remove MIHP services from the contract and allow MIHP providers to bill DCH directly. Specifically, DCH proposes the following revisions to Sections II-G-1 and II-G-3 of the contract, respectively:

1. Services Included
 - ~~Maternal Infant Health Program (MIHP)~~
3. Services Covered Outside of the Contract
 - Maternal Infant Health Program (MIHP)

Section II-H-4 (Maternal Infant Health Program) is deleted entirely. Section II-L-7(c) is revised to clarify that MHPs are required to have coordination of care agreements with all MIHP providers in the plans' service area. Specifically, add two new paragraphs at the end of section II-L-7(c) that read as follows:

Contractors must establish and maintain agreements with the Maternal Infant Health Program (MIHP) providers in the Contractor's services area. Agreements between the Contractor and the MIHP providers must address the following issues:

- **Medical coordination, include pharmacy and laboratory coordination**
- **Data and reporting requirements**
- **Quality assurance coordination**
- **Grievance and appeal resolution**
- **Dispute resolution**

These agreements must be available for review upon request from DCH. The Contractor must present evidence of care coordination to DCH upon request.

Contractors must refer all pregnant enrollees for MIHP screening and coordinate care with MIHP providers. The Contractor must present evidence of referrals and care coordination to DCH upon request.

Rationale: Local Health Departments and other MIHP providers expressed concern about access to MIHP services once all pregnant women became mandatorily enrolled in MHPs. DCH determined that the carve out of MIHP services represented a good compromise between enrolling pregnant women in MHPs without any potential impact on MIHP services. However, it is imperative that MIHP providers and MHPs coordinate care.

Contract Change #14: Tobacco Cessation

Modify the contract to clarify MHPs' responsibilities to cover tobacco cessation services. Specifically, revise Section II-G, by adding the following bullet to the alphabetized list of covered services:

- **Tobacco cessation treatment including pharmaceutical and behavioral support**

Further explain the covered service in Section II-H by specifying the coverage provisions specific to tobacco cessation treatment. Specifically, add a new paragraph at the end of Section II-H that reads as follows:

20. Tobacco Cessation Treatment

The Contractor must provide covered Tobacco Cessation Treatment that includes, at a minimum, the following services:

- Intensive tobacco use treatment through an MDCH approved quit line.
- Over-the-counter agents (patch and also gum or lozenge) used to promote smoking cessation
- One prescription non-nicotine medication used to promote smoking cessation

The Contractor may place a reasonable limit on the type and frequency of over-the-counter and prescription agents covered under this benefit. The Contractor may also require prior authorization for prescription drugs. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

Rationale: DCH determined that further guidelines were needed to ensure that all MHPs were provided the tobacco cessation benefit as expected by DCH. The language is intended to provide a set of clear requirements for MHPs to follow when designing the plan's tobacco cessation program.

Contract Change #15: Pregnant Women Continuity of Care

Modify Section II-H-20 to emphasize MHP's responsibilities regarding continuity of care for pregnant enrollees. Specifically, Section II-H-20 is revised to read as follows:

Special conditions apply to new ~~mandatory~~ Enrollees in the Contractor's health plan whose **are pregnant at the time of enrollment**. ~~Medicaid eligibility was determined based on pregnancy.~~ These Enrollees must be allowed to select or remain with the Medicaid obstetrician of her choice and are entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from the health plan. **The services may be provided without preauthorization regardless of whether the provider is a contracted network provider.** In the event that the Contractor does not have a contract with the provider, all claims should be paid at the Medicaid fee-for-service rate.

Rationale: Certain stakeholders expressed concern that mandatory enrollment of pregnant women into MHPs would impair continuity of care for these women. This language is designed to ensure that MHPs allow enrollees to continue receiving obstetrical services from a provider rendering service at the time of enrollment. The language emphasizes that such services may be provided without prior authorization regardless of the existence of a contract

Contract Change #16: Provider Contracts

Modify Section II-L-7(f) to clarify that co-payment provisions in provider contracts are not required if the MHP does not require a co-payment for the service. Specifically, modify the last bullet in Section II-L-7(f) to read as follows:

- **If the plan utilizes co-payments for the covered service**, prohibit the provider from denying services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

Contract Change #17: Grievance and Appeal Policies

Modify the contract to require MHPs to submit Grievance and Appeal policies to DCH, as well as the Office of Financial and Insurance Regulations (OFIR) for approval. Specifically, revise the introductory paragraph of Section II-T-1 to read as follows:

1. Contractor Grievance/Appeal Procedure Requirements

The Contractor must have written policies and procedures governing the resolution of grievances and appeals. **DCH must approve the Contractor's grievance and appeal**

policies prior to implementation. These written policies and procedures will meet the following requirements:

Rationale: MHPs are subject to both Michigan Law and the Federal Law governing the development and administration of grievance and appeal policies. DCH, focusing on the Federal law, and OFIR, focusing on Michigan Law, have developed joint guidelines for the approval of MHP Grievance/Appeal Policies in order to minimize the confusion for MHPs. However, it is important that both entities review the policies to ensure that all provision of both Michigan and Federal laws are address in the policies.

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 19, 2007

CHANGE NOTICE NO. 11
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 331-4284 Chris Scherer
Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Cscherer@qlhp.com		
		BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH		
CONTRACT PERIOD: From: October 1, 2004		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 October 1, 2007, the attached changes are incorporated into this Contract. Furthermore, FY08 rates are included in the Contract. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$667,875,969.33

FOR THE VENDOR:

Great Lakes Health Plan Inc.

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature
Elise A. Lancaster

 Name
Director, Purchasing Operations

 Title

 Date

CHANGES FOR THE FY08 MEDICAID HEALTH PLAN CONTRACT

Effective Date 10/1/07

Contract Change #1 – Service Area Expansions

Modify section II-C (Targeted Geographical Area for Implementation of the CHCP) to clarify the State's policy with regard to the approval of requests for service area expansion. Specifically, modify Section II-C-2 to clarify that approval of requests will be at the sole discretion of the State.

DCH may consider Contractors' requests for service area expansion during the term of the Contract. Approval of service area expansion requests will be at the sole discretion of the State. ~~and will be contingent upon~~ The state may consider certain factors **including, but not limited to**, the need for additional capacity, **Contractor performance, Contractor fiscal status, and Contractor provider network.** ~~in the counties proposed under the expansion request.~~ Requests should be submitted using the provider profile information form contained in Appendix 1 of the Contract.

Rationale

This change clarifies that the State reserves the right to determine criteria upon which requests for service area expansion are approved.

Contract Change #2 – Change in Mandatory Population

Modify Sections II-D-1, II-D-2, and II-H to reflect that pregnant women, whose pregnancy is the basis for Medicaid eligibility, residing in rural exception counties, are changed from a voluntary to mandatory population. Specifically, modify sections II-D-1 and II-D-2 as follows and add a new section II-H-19.

1. Medicaid Eligible Groups Who Must Enroll in the CHCP:
 - Families with children receiving assistance under the Financial Independence Program (FIP)
 - Persons under age 21 who are receiving Medicaid
 - Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
 - Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
 - Persons receiving Medicaid for the blind or disabled
 - Persons receiving Medicaid for the aged
 - **Pregnant women residing in a county listed in Appendix 6**
2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
 - Migrants
 - Native Americans
 - Pregnant women, whose pregnancy is the basis for Medicaid eligibility, **who do not reside in a county listed in Appendix 6**

II-H-19. Pregnant Women

Special conditions apply to new mandatory Enrollees in the Contractor's health plan whose Medicaid eligibility was determined based on pregnancy. These Enrollees must be allowed to select or remain with the Medicaid obstetrician of her choice and are entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from the health plan. In the event that the

Contractor does not have a contract with the provider, all claims should be paid at the Medicaid fee-for-service rate.

Rationale

The single MHP operating in the Upper Peninsula counties through the rural exception waiver maintains an extensive provider network. The network includes all Local Health Departments and the overwhelming majority of obstetricians practicing in the Upper Peninsula. Therefore, pregnant women in these counties may be made a mandatory population without impairment to continuity of care and further will receive all of the benefits from managed care such as case management and ease of transportation. The special coverage provisions are included to emphasize DCH requirements regarding new mandatory-enrolled pregnant women.

Contract Change #3 – Special Disenrollments

Modify Section II-F-11 (a) (Disenrollment Requests Initiated by the Contractor, Special Disenrollments) to clarify the circumstances under which Medicaid Health Plans can request a disenrollment for enrollee noncompliance. Specifically, modify section II-F-11(a) as follows:

- Other noncompliance situations involving the ~~failure to follow treatment plan~~; repeated use of non-Contractor providers **when in-network providers are available**; discharge from the practices of available Contractor’s network providers; repeated emergency room use for non-emergent services; and other situations that impede care

Rationale

Based on the State’s review of noncompliance disenrollment requests submitted by the Medicaid Health Plans, the State determined that the language regarding “failure to follow treatment plan” may be broad and misleading. Several factors may impact an enrollee’s failure to follow a treatment plan and a special disenrollment is not appropriate in all cases. Additionally, the State wishes to clarify that repeated use of out-of-network providers is a rationale for special disenrollment only in those cases where in-network providers are available.

Contract Change #4 – State and Federal False Claims Act

Add a new subsection to section II-I (Observance of Federal, State and Local Laws) to specifically require Medicaid Health Plans (MHPs) to comply with all applicable portions of the State and Federal False Claims Act. Specifically, the new Section II-I-9 shall read as follows:

9. Compliance with False Claims Acts

The Contractor shall comply with all applicable provisions of the Federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and state laws specifically include, but are not limited to, the following:

- **Establish and disseminate written policies for employees of the entity (including management) and any contractor or agent of the entity regarding the detection and prevention of waste, fraud, and abuse.**
- **The written policies must include detailed information about the False Claim Act and the other provisions named in section 1902(a)(68)(A).**
- **The written policies must specify the rights of employees to be protected as whistleblowers.**
- **The written policies must also be adopted by the Contractor’s contractors or agents A “contractor” or “agent” includes any contractor, subcontractor, agent, or other**

person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. Contractors or agents that meet or surpass the monetary threshold are subject to the requirements in this Section.

- If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees including an explanation of the rights of employees to be protected as whistleblowers.

Rationale

Based on feedback from the Office of Inspector General and Centers for Medicare and Medicaid Services, Michigan's Medicaid False Claims Act does not include certain specific provisions required under the Deficit Reduction Act. This contract change highlights these provisions and ensures that the MHPs requirements are aligned with the key requirements under the federal law.

Contract Change #5 – Reporting Fraud and Abuse

Modify Section II-L-4 (Program Integrity) to more specifically define the requirements regarding Contractor fraud and abuse reporting requirements. Specifically, modify this section as indicated:

1. Program Integrity

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan. The Contractors' arrangements or procedures must include the following as defined in 42 CFR 438.608:

- Written policies and procedures that describes how the Contractor will comply with federal and state fraud and abuse standards.
- The designation of a compliance officer and a compliance committee who are accountable to the senior management or Board of Directors and who have effective lines of communication to the Contractor's employees.
- Effective training and education for the compliance officer and the Contractor's employees.
- Provisions for internal monitoring and auditing.
- Provisions for prompt response to detected offenses and for the development of corrective action initiatives.
- Documentation of the Contractor's enforcement of the Federal and State fraud and abuse standards.

Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the DCH's programs must report directly to the DCH by calling (866) 428-0005 or sending a memo or letter to:

Program Investigations Section
Capitol Commons Center Building
400 S. Pine Street, 6th floor
Lansing, Michigan 48909

The Contractor ~~should~~ must report all suspected fraud and/or abuse that warrant investigation to the DCH, Program Investigation Section.

~~When reporting suspected fraud and/or abuse, Additionally, the Contractor shall provide the number of complaints that warrant a preliminary investigation each year. Further, for each complaint that warrants full investigation, the Contractor must provide to the DCH Program Investigation Section the following information:~~

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

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

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

Rationale

The current contract does not include all the reporting components specified in the Balanced Budget Act. The contract change is necessary to bring the contract into alignment with all specific requirements of 42 CFR 455.17. All information required in this section remains an integral component of the fraud and abuse site visits.

Contract Change #6 – Payment to Providers

Modify Section II-M (Payment to Providers) to incorporate language that enables MHPs to collaborate with DCH and providers in the development and implementation of programs for improving access, quality, and performance. Specifically, modify the introductory paragraph to read as follows:

The Contractor must make timely payments to all providers for covered services rendered to enrollees as required by MCL 400.111i and in compliance with established DCH performance standards (Appendix 4). **Upon request from DCH, Contractors must develop programs for improving access, quality, and performance with providers. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network providers dictated by the methodology jointly developed by the Contractor and DCH.**

With the exception of newborns, the Contractor will not be responsible for any payments owed to providers for services rendered prior to a beneficiary's enrollment with the Contractor's plan. Except for newborns, payment for services provided during a period of retroactive eligibility will be the responsibility of DCH.

Rationale

The intent of this contract change is to enable MHPs and DCH to work collaboratively to develop innovative programs with health care providers. The contract language permits MHPs to make payments to providers that participate in the programs designed to improve access, quality and performance.

Contract Change #7 – Clinical Practice Guidelines

Modify section II-O-I to clarify the time period required for provider assessment, feedback, and review of clinical practice guidelines. Specifically, the 7th and 8th bullet requirement for the written quality plan will be changed as follows:

- At least ~~twice~~ annually, provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor.
- Develop, ~~and/or~~ adopt, **and periodically review** clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards.

Rationale

This contract change is designed to better align the contract provisions with the requirements included as part of the on-site review process.

Contract Change #8 – Consumer Survey

Modify section II-O-6 to reflect the name change of the Consumer Assessment survey. Specifically, the first sentence of section II-O-6 will be changed as follows:

- Contractors must conduct an annual survey of their adult enrollee population using the Consumer Assessment of **Healthcare Providers and Systems Plan Survey** (CAHPS®) instrument.

Rationale

The contract change is needed to accurately reflect the description of the CAHPS survey.

Contract Change #9 – Prevalent Language

Modify Section II-S (Enrollee Services) to clarify Contractor's requirements regarding the provision of interpretation services. Specifically, revise the fourth paragraph in Section II-S-3 to read as follows:

The handbook must be written at no higher than a 6.9 grade reading level and must be available in alternative formats for enrollees with special needs. Member handbooks must be available in a prevalent language when more than five percent (5%) of the Contractor's enrollees speak a prevalent language, as defined by the Contract. Contractors must also provide a mechanism for enrollees who speak the prevalent language to obtain member materials in the prevalent language **and a mechanism for enrollees** ~~or~~ to obtain assistance with interpretation. The Contractor must agree to make modifications in the handbook language ~~so as~~ to comply with the specifications of this Contract.

Rationale

The current contract does not clearly delineate language requirements for written materials and language requirements for oral interpretations services. The Balanced Budget Act Checklist provided by the Center for Medicare and Medicaid Services emphasizes that managed care organizations must make oral interpretation services available free of charge to all enrollees not just enrollees who speak the prevalent non-English language.

Contract Change #10 – Provider Directory

Modify section II-S-2 to clarify that all Contractors are required to place the provider directory on a web site available to the members. Prior to this contract change, placing the provider directory on the Contractor's web site was options. Specifically, modify the final bullet of II-S-2(a) as follows:

- A website, maintained by the Contractor, that includes information on preventive health strategies, health/wellness promotion programs offered by the Contractor, updates related to covered services, access to providers, **complete provider directory**, and updated policies and procedures.

Additionally, because placing the provider directory on the web site is no longer optional, the following changes are needed in the final paragraph of II-S-3:

~~If~~The Contractor **must** maintains a complete provider directory on the Contractor's web site; the Contractor is not required to a mail provider directory to all new enrollees. The web provider directory must be reviewed for accuracy and updated at least monthly. The Contractor must inform new enrollees that the provider directory is available upon request and on the Contractor's web site and must mail the provider directory within five business days of the enrollee's request

Rationale

Most MHPs have chosen to the place the provider directory on the web site. With the increasing access to computers, providing access to the provider directory on the web site may improve access to network providers and facilitate compliance with network limitations. Because the provider directory will be available on the web site, MHPs are only required to mail the provider directory to members upon request.

Contract Change #11 - Payment Withhold

Modify Section II-Z-1(Contractor Performance Bonus) to reflect the revised withhold amount. DCH has increased the threshold to .19%. The first sentence of this section will read as follows:

During each Contract year, DCH will withhold ~~.0012~~ **.0019** of the approved capitation payment from each Contractor until the performance bonus withhold reaches approximately \$35.0 million dollars.

Rationale

In order to implement an increased performance bonus withhold of approximately \$5.0 million, DCH must increase the percentage of the capitation withhold amount.

Contract Change #12 – Appendix 6

Insert a new appendix at the end of the contract that lists the rural exception counties in which pregnant women will be a mandatory population. Specifically, the newly inserted Appendix 6 will read as follows:

**Appendix 6
Rural Exception Counties in which Pregnant Women are a Mandatory Population**

Alger
Baraga
Chippewa
Delta
Dickinson
Gogebic
Houghton
Iron
Keweenaw
Luce
Mackinac
Marquette
Menominee
Ontonagon
Schoolcraft

Rationale

The Centers for Medicare and Medicaid Services requested that the Department specifically lists the counties in which pregnant women would be a mandatory population.

MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2007 – September 30, 2008)

Appendix 4 – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. The performance monitoring standards are part of the Contract between the State of Michigan and Contracting Health Plans (Appendix 4).

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

The Performance Monitoring Standards address the following performance areas:

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

For each performance area the following categories are identified:

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

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract section II-V.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> Quality of Care: Childhood Immunization Status 	Fully immunize children who turn two years old during the calendar year.	Combination 2 ≥ 82%	HEDIS report	Annual
<ul style="list-style-type: none"> Quality of Care: Prenatal Care 	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥ 85%	MDCH Data Warehouse	Quarterly
<ul style="list-style-type: none"> Quality of Care: Postpartum Care 	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥ 62%	HEDIS report	Annual
<ul style="list-style-type: none"> Quality of Care: Blood Lead Testing 	Children at the age of 3 years old receive at least one blood lead test on/before 3 rd birthday	≥ 80% for total enrollment and ≥ 80% for continuous enrollment	MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> Access to care: Well-Child Visits in the First 15 Months of Life 	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 60%	Encounter data	Quarterly
<ul style="list-style-type: none"> Access to care: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life 	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 68%	Encounter data	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> <u>Customer Services:</u> Enrollee Complaints 	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < .25 per 1000 member months	Beneficiary/ Provider contacts tracking (BPCT)	Quarterly
<ul style="list-style-type: none"> <u>Claims Reporting and Processing</u> 	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥95% of clean claims paid within 30 days, and ≤1.85% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
<ul style="list-style-type: none"> <u>Encounter Data Reporting (Institutional, Professional)</u> 	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange (DEG) and MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> <u>Encounter Data Reporting (Pharmacy)</u> 	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange (DEG) and MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> <u>Provider File Reporting</u> 	Timely and accurate provider file update/submission before the last Tuesday of the month	Timely and Complete submission	MI Enrolls	Monthly

Minimum standard will be updated effective October 1, 2007 for HEDIS measures based on 2007 HEDIS Michigan Medicaid Avg.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; County 82
Region 01

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	356.82	112.83	39.18	3.38	512.21	0.996			510.16	-0.97	509.19
2	TANF < 1	F	329.61	98.22	34.77	3.38	465.98	0.996			464.12	-0.88	463.24
3	TANF 1 - 4	M	85.16	15.43	2.33	3.38	106.3	0.996			105.87	-0.20	105.67
4	TANF 1 - 4	F	69.67	10.59	1.73	3.38	85.37	0.996			85.03	-0.16	84.87
5	TANF 5 - 14	M	54.51	7.12	0.96	3.38	65.97	0.996			65.71	-0.12	65.59
6	TANF 5 - 14	F	46.82	6.12	0.85	3.38	57.17	0.996			56.94	-0.11	56.83
7	TANF 15 - 20	M	56.48	10.11	1.76	3.38	71.73	0.996			71.44	-0.14	71.30
8	TANF 15 - 20	F	84.04	12.68	2.06	3.38	102.16	0.996			101.75	-0.19	101.56
9	TANF 21 - 25	M	94.10	21.43	3.69	3.38	122.6	0.996			122.11	-0.23	121.88
10	TANF 21 - 25	F	150.86	30.15	5.63	3.38	190.02	0.996			189.26	-0.36	188.90
11	TANF 26 - 44	M	213.46	45.38	10.83	3.38	273.05	0.996			271.96	-0.52	271.44
12	TANF 26 - 44	F	220.76	44.85	8.21	3.38	277.2	0.996			276.09	-0.52	275.57
13	TANF 45 +	M	407.57	82.90	21.09	3.38	514.94	0.996			512.88	-0.97	511.91
14	TANF 45 +	F	416.01	91.52	19.29	3.38	530.2	0.996			528.08	-1.00	527.08
15	ABAD 0 - 20	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
16	ABAD 0 - 20	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
17.1	ABAD 21 - 39 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
18.1	ABAD 21 - 39 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
17.2	ABAD 21 - 39	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
18.2	ABAD 21 - 39	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
19.1	ABAD 40 - 64 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
20.1	ABAD 40 - 64 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
19.2	ABAD 40 - 64	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
20.2	ABAD 40 - 64	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
21.1	ABAD 65 + Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
22.1	ABAD 65 + Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
21.2	ABAD 65 +	M	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
22.2	ABAD 65 +	F	639.42	146.88	36.85	6.76	829.91		1.1120		922.86	-1.75	921.11
23.1	OAA 0 + Medicare	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.1	OAA 0 + Medicare	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
23.2	OAA 0 +	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.2	OAA 0 +	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
59.9	Rate MCR		4,529.56	1545.03	605.58	0.00	6680.17				6,680.17	-12.69	6667.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

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**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 30, 38, 46, 47

Region 02

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	1.029			494.63	-0.94	493.69
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	1.029			446.12	-0.85	445.27
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	1.029			104.06	-0.20	103.86
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	1.029			88.09	-0.17	87.92
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	1.029			78.92	-0.15	78.77
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	1.029			67.48	-0.13	67.35
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	1.029			88.05	-0.17	87.88
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	1.029			138.62	-0.26	138.36
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	1.029			132.22	-0.25	131.97
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	1.029			236.25	-0.45	235.80
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	1.029			306.74	-0.58	306.16
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	1.029			333.83	-0.63	333.20
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	1.029			551.61	-1.05	550.56
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	1.029			587.11	-1.12	585.99
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		0.9050		678.24	-1.29	676.95
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,246.33	1298.79	522.24	0.00	6067.36				6,067.36	-11.53	6056.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

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**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 11, 12, 13, 14, 39, 75, 80
Region 03

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	0.998			479.73	-0.91	478.82
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	0.998			432.68	-0.82	431.86
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	0.998			100.93	-0.19	100.74
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	0.998			85.44	-0.16	85.28
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	0.998			76.55	-0.15	76.40
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	0.998			65.45	-0.12	65.33
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	0.998			85.40	-0.16	85.24
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	0.998			134.44	-0.26	134.18
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	0.998			128.23	-0.24	127.99
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	0.998			229.13	-0.44	228.69
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	0.998			297.50	-0.57	296.93
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	0.998			323.77	-0.62	323.15
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	0.998			534.99	-1.02	533.97
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	0.998			569.42	-1.08	568.34
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		0.9710		727.71	-1.38	726.33
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,211.77	1298.79	522.24	0.00	6032.8				6,032.80	-11.46	6021.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 32, 73, 76, 79
Region 07

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	1.009			485.02	-0.92	484.10
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	1.009			437.45	-0.83	436.62
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	1.009			102.04	-0.19	101.85
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	1.009			86.38	-0.16	86.22
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	1.009			77.39	-0.15	77.24
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	1.009			66.17	-0.13	66.04
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	1.009			86.34	-0.16	86.18
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	1.009			135.92	-0.26	135.66
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	1.009			129.65	-0.25	129.40
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	1.009			231.66	-0.44	231.22
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	1.009			300.78	-0.57	300.21
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	1.009			327.34	-0.62	326.72
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	1.009			540.88	-1.03	539.85
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	1.009			575.70	-1.09	574.61
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		1.0540		789.91	-1.50	788.41
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,190.98	1298.79	522.24	0.00	6012.01				6,012.01	-11.42	6001.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 50, 74
Region 09

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	356.82	112.83	39.18	3.38	512.21	0.998			511.19	-0.97	510.22
2	TANF < 1	F	329.61	98.22	34.77	3.38	465.98	0.998			465.05	-0.88	464.17
3	TANF 1 - 4	M	85.16	15.43	2.33	3.38	106.3	0.998			106.09	-0.20	105.89
4	TANF 1 - 4	F	69.67	10.59	1.73	3.38	85.37	0.998			85.20	-0.16	85.04
5	TANF 5 - 14	M	54.51	7.12	0.96	3.38	65.97	0.998			65.84	-0.13	65.71
6	TANF 5 - 14	F	46.82	6.12	0.85	3.38	57.17	0.998			57.06	-0.11	56.95
7	TANF 15 - 20	M	56.48	10.11	1.76	3.38	71.73	0.998			71.59	-0.14	71.45
8	TANF 15 - 20	F	84.04	12.68	2.06	3.38	102.16	0.998			101.96	-0.19	101.77
9	TANF 21 - 25	M	94.10	21.43	3.69	3.38	122.6	0.998			122.35	-0.23	122.12
10	TANF 21 - 25	F	150.86	30.15	5.63	3.38	190.02	0.998			189.64	-0.36	189.28
11	TANF 26 - 44	M	213.46	45.38	10.83	3.38	273.05	0.998			272.50	-0.52	271.98
12	TANF 26 - 44	F	220.76	44.85	8.21	3.38	277.2	0.998			276.65	-0.53	276.12
13	TANF 45 +	M	407.57	82.90	21.09	3.38	514.94	0.998			513.91	-0.98	512.93
14	TANF 45 +	F	416.01	91.52	19.29	3.38	530.2	0.998			529.14	-1.01	528.13
15	ABAD 0 - 20	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
16	ABAD 0 - 20	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
17.1	ABAD 21 - 39 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
18.1	ABAD 21 - 39 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
17.2	ABAD 21 - 39	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
18.2	ABAD 21 - 39	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
19.1	ABAD 40 - 64 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
20.1	ABAD 40 - 64 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
19.2	ABAD 40 - 64	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
20.2	ABAD 40 - 64	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
21.1	ABAD 65 + Medicare	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
22.1	ABAD 65 + Medicare	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
21.2	ABAD 65 +	M	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
22.2	ABAD 65 +	F	639.42	146.88	36.85	6.76	829.91		1.1020		914.56	-1.74	912.82
23.1	OAA 0 + Medicare	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.1	OAA 0 + Medicare	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
23.2	OAA 0 +	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.2	OAA 0 +	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
59.9	Rate MCR		4,377.00	1545.03	605.58	0.00	6527.61				6,527.61	-12.40	6515.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; County 63
Region 10

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	356.82	112.83	39.18	3.38	512.21	1.022			523.48	-0.99	522.49
2	TANF < 1	F	329.61	98.22	34.77	3.38	465.98	1.022			476.23	-0.90	475.33
3	TANF 1 - 4	M	85.16	15.43	2.33	3.38	106.3	1.022			108.64	-0.21	108.43
4	TANF 1 - 4	F	69.67	10.59	1.73	3.38	85.37	1.022			87.25	-0.17	87.08
5	TANF 5 - 14	M	54.51	7.12	0.96	3.38	65.97	1.022			67.42	-0.13	67.29
6	TANF 5 - 14	F	46.82	6.12	0.85	3.38	57.17	1.022			58.43	-0.11	58.32
7	TANF 15 - 20	M	56.48	10.11	1.76	3.38	71.73	1.022			73.31	-0.14	73.17
8	TANF 15 - 20	F	84.04	12.68	2.06	3.38	102.16	1.022			104.41	-0.20	104.21
9	TANF 21 - 25	M	94.10	21.43	3.69	3.38	122.6	1.022			125.30	-0.24	125.06
10	TANF 21 - 25	F	150.86	30.15	5.63	3.38	190.02	1.022			194.20	-0.37	193.83
11	TANF 26 - 44	M	213.46	45.38	10.83	3.38	273.05	1.022			279.06	-0.53	278.53
12	TANF 26 - 44	F	220.76	44.85	8.21	3.38	277.2	1.022			283.30	-0.54	282.76
13	TANF 45 +	M	407.57	82.90	21.09	3.38	514.94	1.022			526.27	-1.00	525.27
14	TANF 45 +	F	416.01	91.52	19.29	3.38	530.2	1.022			541.86	-1.03	540.83
15	ABAD 0 - 20	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
16	ABAD 0 - 20	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
17.1	ABAD 21 - 39 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
18.1	ABAD 21 - 39 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
17.2	ABAD 21 - 39	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
18.2	ABAD 21 - 39	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
19.1	ABAD 40 - 64 Medicare	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
20.1	ABAD 40 - 64 Medicare	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
19.2	ABAD 40 - 64	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
20.2	ABAD 40 - 64	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
21.1	ABAD 65 + Medicare	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
22.1	ABAD 65 + Medicare	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
21.2	ABAD 65 +	M	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
22.2	ABAD 65 +	F	639.42	146.88	36.85	6.76	829.91		1.0770		893.81	-1.70	892.11
23.1	OAA 0 + Medicare	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.1	OAA 0 + Medicare	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
23.2	OAA 0 +	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.2	OAA 0 +	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
59.9	Rate MCR		4,512.89	1545.03	605.58	0.00	6663.5				6,663.50	-12.66	6651.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

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

July 26, 2007

CHANGE NOTICE NO. 10
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 331-4284 Chris Scherer
Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Cscherer@qlhp.com		BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH		
CONTRACT PERIOD: From: October 1, 2004		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 INCREASED by \$186,469,164.00, and the Contract is EXTENDED through September 30, 2008. All other terms, conditions, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request, Ad Board approval on July 17, 2007, and DMB/Purchasing Operations.

INCREASE: \$186,469,164.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$667,875,969.33

FOR THE VENDOR:

Great Lakes Health Plan Inc.

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature
Elise A. Lancaster

 Name
Director, Purchasing Operations

 Title

 Date

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 20, 2007

CHANGE NOTICE NO. 9
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Cscherer@qlhp.com	TELEPHONE (248) 331-4284 Chris Scherer
	BUYER/CA (517) 241-4225 Kevin Dunn
	Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 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 January 1, 2007, the attached changes are hereby incorporated into this Contract. Furthermore, FY07 rates are included in the Contract. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request and DMB/Purchasing Operations approval.

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$481,406,805.33

FOR THE VENDOR:

Great Lakes Health Plan Inc.
 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature
Elise A. Lancaster
 Name
Director, Purchasing Operations
 Title

 Date

CHANGES FOR FY07 MEDICAID HEALTH PLAN CONTRACT

Proposed Effective Date 1/1/07

1 - Dental Benefits

Modify Section II-H of the Contract (Special Coverage Provisions) to reflect that the Department will continue to directly provide dental benefits for enrollees under 21. Specifically, remove the entire Section II-H-19 (Dental Services for Members Under 21 Years of Age) describing MHPs' role as the Department's third party administrator of dental services for enrollees under 21 years of age. Renumber the remainder of Section II-H as appropriate

Rationale

After further analysis of the costs and benefits, the Department has elected not to implement the proposed dental program. DCH will continue to provide benefits to enrollees under 21 years of age directly through fee-for-service.

2 - Hospital Payments

Modify Section II-M-7 to specify that hospital payments must include GME payments. Specifically, revise the first paragraph of Section II-M-7 to read as follows:

7. Hospital Payments

Contractors must pay out-of-network hospitals for all emergency and authorized covered services provided outside of the established network. Out-of-network hospital claims must be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid providers. Hospital payments must include payment for the Diagnosis Related Groups (DRGs, as defined in the Medicaid Institutional Provider Chapter IV), outliers, as applicable, and capital costs at the per-discharge rate. Hospital payments must also include **the applicable Graduate Medical Education (GME) payment in the amount and on the schedule dictated by DCH.**

Rationale

The contract change is necessary since the GME payment component was omitted in error from the original contract.

3 - Innovation Health Care Delivery Programs

Modify Section II-M-7 (Hospital Payments) and II-AA to clarify language regarding the innovative programs. Specifically, revise the second paragraph of Section II-L-7 to read as follows:

Upon request from DCH, Contractors must develop ~~incentive~~ programs for improving access, quality, and performance with both network and out-of-network hospitals. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network hospitals dictated by the methodology jointly developed by the Contractor and DCH.

Further, modify the second to the last bullet in the bulleted list in Section II-AA (DCH Responsibilities) to read as follows:

- Participate with Contractors in the design, data collection, and evaluation of system-wide ~~incentive~~ programs to improve access, quality and performance.

Rationale

The contract change clarifies that the joint MHP-hospital programs described in these contract sections are not traditional incentive programs but innovative programs designed to improve quality, access and performance across health care delivery systems.

4 - Payment Withhold

Modify Section II-Z-1(Contractor Performance Bonus) to reflect the revised withhold amount. DCH has lowered the threshold to .12%. The first sentence of this section will read as follows:

During each Contract year, DCH will withhold .0012 of the approved capitation payment from each Contractor until the performance bonus withhold reaches approximately \$3.0 million dollars.

Rationale

With the increase in capitation rates, the percent of withhold must be reduced to enable DCH to better limit the performance bonus withhold to \$3.0 million dollars.

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; County 82
Region 01

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	180.38	30.34	18.64	\$229.36	1.002			229.82	-0.28	229.54
2	TANF < 1	F	168.00	28.97	18.75	\$215.72	1.002			216.15	-0.26	215.89
3	TANF 1 - 4	M	82.00	9.06	3.57	\$94.63	1.002			94.82	-0.11	94.71
4	TANF 1 - 4	F	68.30	6.87	2.94	\$78.11	1.002			78.27	-0.09	78.18
5	TANF 5 - 14	M	60.87	7.05	1.35	\$69.27	1.002			69.41	-0.08	69.33
6	TANF 5 - 14	F	52.68	5.53	0.94	\$59.15	1.002			59.27	-0.07	59.20
7	TANF 15 - 20	M	70.83	11.34	3.42	\$85.59	1.002			85.76	-0.10	85.66
8	TANF 15 - 20	F	100.57	14.02	4.49	\$119.08	1.002			119.32	-0.14	119.18
9	TANF 21 - 25	M	91.69	15.94	3.26	\$110.89	1.002			111.11	-0.13	110.98
10	TANF 21 - 25	F	153.88	22.37	8.87	\$185.12	1.002			185.49	-0.22	185.27
11	TANF 26 - 44	M	205.32	30.15	12.27	\$247.74	1.002			248.24	-0.30	247.94
12	TANF 26 - 44	F	197.69	27.14	11.14	\$235.97	1.002			236.44	-0.28	236.16
13	TANF 45 +	M	514.09	101.66	34.73	\$650.48	1.002			651.78	-0.78	651.00
14	TANF 45 +	F	375.70	53.11	18.94	\$447.75	1.002			448.65	-0.54	448.11
15	ABAD 0 - 20	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
16	ABAD 0 - 20	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
17.1	ABAD 21 - 39 Medicare	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
18.1	ABAD 21 - 39 Medicare	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
17.2	ABAD 21 - 39	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
18.2	ABAD 21 - 39	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
19.1	ABAD 40 - 64 Medicare	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
20.1	ABAD 40 - 64 Medicare	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
19.2	ABAD 40 - 64	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
20.2	ABAD 40 - 64	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
21.1	ABAD 65 + Medicare	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
22.1	ABAD 65 + Medicare	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
21.2	ABAD 65 +	M	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
22.2	ABAD 65 +	F	677.71	116.44	32.60	\$826.75		1.1210		926.79	-1.11	925.68
23.1	OAA 0 + Medicare	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
24.1	OAA 0 + Medicare	F	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
23.2	OAA 0 +	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
24.2	OAA 0 +	F	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
59.9	Rate MCR		4,517.35	981.24	684.62	\$6,183.21				6,183.21	-7.42	6175.79

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 30, 38, 46, 47
Region 02

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	214.15	32.33	19.36	\$265.84	1.030			273.82	-0.33	273.49
2	TANF < 1	F	186.33	26.72	16.23	\$229.28	1.030			236.16	-0.28	235.88
3	TANF 1 - 4	M	76.93	8.56	2.22	\$87.71	1.030			90.34	-0.11	90.23
4	TANF 1 - 4	F	65.03	6.56	1.85	\$73.44	1.030			75.64	-0.09	75.55
5	TANF 5 - 14	M	59.21	5.54	1.23	\$65.98	1.030			67.96	-0.08	67.88
6	TANF 5 - 14	F	51.16	4.61	1.05	\$56.82	1.030			58.52	-0.07	58.45
7	TANF 15 - 20	M	69.70	9.89	2.07	\$81.66	1.030			84.11	-0.10	84.01
8	TANF 15 - 20	F	104.91	12.97	3.64	\$121.52	1.030			125.17	-0.15	125.02
9	TANF 21 - 25	M	96.87	16.32	4.97	\$118.16	1.030			121.70	-0.15	121.55
10	TANF 21 - 25	F	169.22	26.42	8.39	\$204.03	1.030			210.15	-0.25	209.90
11	TANF 26 - 44	M	210.45	34.29	11.66	\$256.40	1.030			264.09	-0.32	263.77
12	TANF 26 - 44	F	230.59	32.43	10.30	\$273.32	1.030			281.52	-0.34	281.18
13	TANF 45 +	M	454.93	82.09	28.82	\$565.84	1.030			582.82	-0.70	582.12
14	TANF 45 +	F	478.76	77.27	23.55	\$579.58	1.030			596.97	-0.72	596.25
15	ABAD 0 - 20	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
16	ABAD 0 - 20	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
17.1	ABAD 21 - 39 Medicare	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
18.1	ABAD 21 - 39 Medicare	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
17.2	ABAD 21 - 39	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
18.2	ABAD 21 - 39	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
19.1	ABAD 40 - 64 Medicare	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
20.1	ABAD 40 - 64 Medicare	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
19.2	ABAD 40 - 64	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
20.2	ABAD 40 - 64	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
21.1	ABAD 65 + Medicare	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
22.1	ABAD 65 + Medicare	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
21.2	ABAD 65 +	M	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
22.2	ABAD 65 +	F	587.48	95.31	28.19	\$710.98		0.9260		658.37	-0.79	657.58
23.1	OAA 0 + Medicare	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.1	OAA 0 + Medicare	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
23.2	OAA 0 +	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.2	OAA 0 +	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
59.9	Rate MCR		4,093.46	971.70	687.16	\$5,752.32				5,752.32	-6.90	5745.42

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 11, 12, 13, 14, 39, 75, 80
Region 03

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	214.15	32.33	19.36	\$265.84	0.981			260.79	-0.31	260.48
2	TANF < 1	F	186.33	26.72	16.23	\$229.28	0.981			224.92	-0.27	224.65
3	TANF 1 - 4	M	76.93	8.56	2.22	\$87.71	0.981			86.04	-0.10	85.94
4	TANF 1 - 4	F	65.03	6.56	1.85	\$73.44	0.981			72.04	-0.09	71.95
5	TANF 5 - 14	M	59.21	5.54	1.23	\$65.98	0.981			64.73	-0.08	64.65
6	TANF 5 - 14	F	51.16	4.61	1.05	\$56.82	0.981			55.74	-0.07	55.67
7	TANF 15 - 20	M	69.70	9.89	2.07	\$81.66	0.981			80.11	-0.10	80.01
8	TANF 15 - 20	F	104.91	12.97	3.64	\$121.52	0.981			119.21	-0.14	119.07
9	TANF 21 - 25	M	96.87	16.32	4.97	\$118.16	0.981			115.91	-0.14	115.77
10	TANF 21 - 25	F	169.22	26.42	8.39	\$204.03	0.981			200.15	-0.24	199.91
11	TANF 26 - 44	M	210.45	34.29	11.66	\$256.40	0.981			251.53	-0.30	251.23
12	TANF 26 - 44	F	230.59	32.43	10.30	\$273.32	0.981			268.13	-0.32	267.81
13	TANF 45 +	M	454.93	82.09	28.82	\$565.84	0.981			555.09	-0.67	554.42
14	TANF 45 +	F	478.76	77.27	23.55	\$579.58	0.981			568.57	-0.68	567.89
15	ABAD 0 - 20	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
16	ABAD 0 - 20	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
17.1	ABAD 21 - 39 Medicare	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
18.1	ABAD 21 - 39 Medicare	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
17.2	ABAD 21 - 39	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
18.2	ABAD 21 - 39	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
19.1	ABAD 40 - 64 Medicare	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
20.1	ABAD 40 - 64 Medicare	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
19.2	ABAD 40 - 64	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
20.2	ABAD 40 - 64	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
21.1	ABAD 65 + Medicare	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
22.1	ABAD 65 + Medicare	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
21.2	ABAD 65 +	M	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
22.2	ABAD 65 +	F	587.48	95.31	28.19	\$710.98		0.9630		684.67	-0.82	683.85
23.1	OAA 0 + Medicare	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.1	OAA 0 + Medicare	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
23.2	OAA 0 +	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.2	OAA 0 +	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
59.9	Rate MCR		4,215.68	971.57	687.06	\$5,874.31				5,874.31	-7.05	5867.26

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 32, 73, 76, 79
Region 07

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	214.15	32.33	19.36	\$265.84	1.013			269.30	-0.32	268.98
2	TANF < 1	F	186.33	26.72	16.23	\$229.28	1.013			232.26	-0.28	231.98
3	TANF 1 - 4	M	76.93	8.56	2.22	\$87.71	1.013			88.85	-0.11	88.74
4	TANF 1 - 4	F	65.03	6.56	1.85	\$73.44	1.013			74.39	-0.09	74.30
5	TANF 5 - 14	M	59.21	5.54	1.23	\$65.98	1.013			66.84	-0.08	66.76
6	TANF 5 - 14	F	51.16	4.61	1.05	\$56.82	1.013			57.56	-0.07	57.49
7	TANF 15 - 20	M	69.70	9.89	2.07	\$81.66	1.013			82.72	-0.10	82.62
8	TANF 15 - 20	F	104.91	12.97	3.64	\$121.52	1.013			123.10	-0.15	122.95
9	TANF 21 - 25	M	96.87	16.32	4.97	\$118.16	1.013			119.70	-0.14	119.56
10	TANF 21 - 25	F	169.22	26.42	8.39	\$204.03	1.013			206.68	-0.25	206.43
11	TANF 26 - 44	M	210.45	34.29	11.66	\$256.40	1.013			259.73	-0.31	259.42
12	TANF 26 - 44	F	230.59	32.43	10.30	\$273.32	1.013			276.87	-0.33	276.54
13	TANF 45 +	M	454.93	82.09	28.82	\$565.84	1.013			573.20	-0.69	572.51
14	TANF 45 +	F	478.76	77.27	23.55	\$579.58	1.013			587.11	-0.70	586.41
15	ABAD 0 - 20	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
16	ABAD 0 - 20	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
17.1	ABAD 21 - 39 Medicare	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
18.1	ABAD 21 - 39 Medicare	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
17.2	ABAD 21 - 39	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
18.2	ABAD 21 - 39	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
19.1	ABAD 40 - 64 Medicare	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
20.1	ABAD 40 - 64 Medicare	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
19.2	ABAD 40 - 64	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
20.2	ABAD 40 - 64	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
21.1	ABAD 65 + Medicare	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
22.1	ABAD 65 + Medicare	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
21.2	ABAD 65 +	M	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
22.2	ABAD 65 +	F	587.48	95.31	28.19	\$710.98		1.0090		717.38	-0.86	716.52
23.1	OAA 0 + Medicare	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.1	OAA 0 + Medicare	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
23.2	OAA 0 +	M	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
24.2	OAA 0 +	F	587.48	95.31	28.19	\$710.98			0.848	602.91	-0.72	602.19
59.9	Rate MCR		4,324.82	971.56	687.06	\$5,983.44				5,983.44	-7.18	5976.26

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; Counties 50, 74
Region 09

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	180.38	30.34	18.64	\$229.36	1.010			231.65	-0.28	231.37
2	TANF < 1	F	168.00	28.97	18.75	\$215.72	1.010			217.88	-0.26	217.62
3	TANF 1 - 4	M	82.00	9.06	3.57	\$94.63	1.010			95.58	-0.11	95.47
4	TANF 1 - 4	F	68.30	6.87	2.94	\$78.11	1.010			78.89	-0.09	78.80
5	TANF 5 - 14	M	60.87	7.05	1.35	\$69.27	1.010			69.96	-0.08	69.88
6	TANF 5 - 14	F	52.68	5.53	0.94	\$59.15	1.010			59.74	-0.07	59.67
7	TANF 15 - 20	M	70.83	11.34	3.42	\$85.59	1.010			86.45	-0.10	86.35
8	TANF 15 - 20	F	100.57	14.02	4.49	\$119.08	1.010			120.27	-0.14	120.13
9	TANF 21 - 25	M	91.69	15.94	3.26	\$110.89	1.010			112.00	-0.13	111.87
10	TANF 21 - 25	F	153.88	22.37	8.87	\$185.12	1.010			186.97	-0.22	186.75
11	TANF 26 - 44	M	205.32	30.15	12.27	\$247.74	1.010			250.22	-0.30	249.92
12	TANF 26 - 44	F	197.69	27.14	11.14	\$235.97	1.010			238.33	-0.29	238.04
13	TANF 45 +	M	514.09	101.66	34.73	\$650.48	1.010			656.98	-0.79	656.19
14	TANF 45 +	F	375.70	53.11	18.94	\$447.75	1.010			452.23	-0.54	451.69
15	ABAD 0 - 20	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
16	ABAD 0 - 20	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
17.1	ABAD 21 - 39 Medicare	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
18.1	ABAD 21 - 39 Medicare	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
17.2	ABAD 21 - 39	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
18.2	ABAD 21 - 39	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
19.1	ABAD 40 - 64 Medicare	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
20.1	ABAD 40 - 64 Medicare	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
19.2	ABAD 40 - 64	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
20.2	ABAD 40 - 64	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
21.1	ABAD 65 + Medicare	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
22.1	ABAD 65 + Medicare	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
21.2	ABAD 65 +	M	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
22.2	ABAD 65 +	F	677.71	116.44	32.60	\$826.75		1.1000		909.42	-1.09	908.33
23.1	OAA 0 + Medicare	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
24.1	OAA 0 + Medicare	F	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
23.2	OAA 0 +	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
24.2	OAA 0 +	F	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
59.9	Rate MCR		4,156.60	981.55	684.83	\$5,822.98				5,822.98	-6.99	5815.99

**State of Michigan Managed Care Rates FY07
Effective January 1, 2007**

Great Lakes Health Plan 0003293040 0003293050; County 63

Region 10

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.12% Bonus W/H	Rate after W/H
1	TANF < 1	M	180.38	30.34	18.64	\$229.36	0.974			223.40	-0.27	223.13
2	TANF < 1	F	168.00	28.97	18.75	\$215.72	0.974			210.11	-0.25	209.86
3	TANF 1 - 4	M	82.00	9.06	3.57	\$94.63	0.974			92.17	-0.11	92.06
4	TANF 1 - 4	F	68.30	6.87	2.94	\$78.11	0.974			76.08	-0.09	75.99
5	TANF 5 - 14	M	60.87	7.05	1.35	\$69.27	0.974			67.47	-0.08	67.39
6	TANF 5 - 14	F	52.68	5.53	0.94	\$59.15	0.974			57.61	-0.07	57.54
7	TANF 15 - 20	M	70.83	11.34	3.42	\$85.59	0.974			83.36	-0.10	83.26
8	TANF 15 - 20	F	100.57	14.02	4.49	\$119.08	0.974			115.98	-0.14	115.84
9	TANF 21 - 25	M	91.69	15.94	3.26	\$110.89	0.974			108.01	-0.13	107.88
10	TANF 21 - 25	F	153.88	22.37	8.87	\$185.12	0.974			180.31	-0.22	180.09
11	TANF 26 - 44	M	205.32	30.15	12.27	\$247.74	0.974			241.30	-0.29	241.01
12	TANF 26 - 44	F	197.69	27.14	11.14	\$235.97	0.974			229.83	-0.28	229.55
13	TANF 45 +	M	514.09	101.66	34.73	\$650.48	0.974			633.57	-0.76	632.81
14	TANF 45 +	F	375.70	53.11	18.94	\$447.75	0.974			436.11	-0.52	435.59
15	ABAD 0 - 20	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
16	ABAD 0 - 20	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
17.1	ABAD 21 - 39 Medicare	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
18.1	ABAD 21 - 39 Medicare	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
17.2	ABAD 21 - 39	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
18.2	ABAD 21 - 39	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
19.1	ABAD 40 - 64 Medicare	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
20.1	ABAD 40 - 64 Medicare	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
19.2	ABAD 40 - 64	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
20.2	ABAD 40 - 64	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
21.1	ABAD 65 + Medicare	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
22.1	ABAD 65 + Medicare	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
21.2	ABAD 65 +	M	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
22.2	ABAD 65 +	F	677.71	116.44	32.60	\$826.75		1.0350		855.69	-1.03	854.66
23.1	OAA 0 + Medicare	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
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23.2	OAA 0 +	M	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
24.2	OAA 0 +	F	677.71	116.44	32.60	\$826.75			0.758	626.68	-0.75	625.93
59.9	Rate MCR		4,651.35	981.49	684.79	\$6,317.63				6,317.63	-7.58	6310.05

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

September 20, 2006

**CHANGE NOTICE NO. 8
 TO
 CONTRACT NO. 071B5200007
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Cscherer@qlhp.com	TELEPHONE (248) 331-4284 Chris Scherer
	BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT with three 1 year renewal options <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 October 1, 2006, this Contract is hereby **EXTENDED** until October 1, 2007 and **INCREASED** by \$165,617,333.33. Also effective October 1, 2006 the attached changes are hereby incorporated into this Contract. All other terms, conditions, specifications and pricing remain unchanged.

Please note: the buyer has been changed to Kevin Dunn.

Total Contract value revised to reflect correct initial two (2) year contract amount (\$315,789,742.000) and change notice number 8 amount (\$165,617,333.33).

AUTHORITY/REASON:

Per DCH request and DMB/Purchasing Operations approval.

Contract No. 071B5200007
Change Notice No. 8
Page Two

INCREASE: \$165,617,333.33

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$481,406,805.33

FOR THE VENDOR:

Great Lakes Health Plan Inc.

Firm Name

Authorized Agent Signature

Authorized Agent (Print or Type)

Date

FOR THE STATE:

Signature

Sean L. Carlson

Name

Chief Procurement Officer

Title

Date

CHANGES FOR FY07 MEDICAID HEALTH PLAN CONTRACT

DEFINITION SECTION CHANGES

1 - Contract Change – Definition of Health Benefit Manager

Add a new definition to the Definitions Section to define Health Benefit Manager to read as follows:

“Health Benefit Manager” means any entity that performs the administration and management of one or more of the required health care benefits listed in Section II-G or Section II-H of the Contract under a written contract or agreement with the Contractor.

Rationale

The term “Health Benefit Manager” is used in section I-F of the contract but has not been defined.

SECTION I CHANGES

2 - Contract Change – Subcontracts and Health Benefit Managers

Modify sections I-F (Contractor Responsibilities) and I-W (Delegation) to clarify Contractor’s allowed actions and notification responsibilities when utilizing administrative subcontractors and Health Benefit Managers. Specifically, modify Section I-F to read as follows:

The Contractor will be responsible for the performance of all the obligations under this Contract, whether the Contractor or a subcontractor performs the obligations. Further, the State will consider the 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, the contractor must notify the state and identify the subcontractor(s), 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~~ **the relevant** provisions of the Contract.

A subcontractor is any person or entity that performs a required, ongoing administrative function of the Contractor under this Contract. Health care providers included in the network of the Contractor and Health Benefit Managers are not considered a subcontractor for purposes of this Contract unless otherwise specifically noted in this Contract. Contracts for one-time only functions or services not directly related to requirements under this Contract, such as maintenance, cleaning, or insurance protection, are not intended to be covered by this section.

Although Contractors may enter into subcontracts, all communications shall take place between the Contractor and the State directly; therefore, all communication by subcontractors must be with the Contractor only, not with the State.

If a Contractor elects to use a subcontractor, **as specified in this section**, ~~not specified included~~ in the Contractor’s response to the ITB, the Contractor must provide DCH with

written notice no later than 21 days after the subcontract effective date. **The Contractor must identify the subcontractor(s), including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities.** Use of a subcontractor without notice to DCH may be cause for termination of the Contract.

Additionally, modify section I-W (Delegation) to clarify that plans must give DCH prior notification of the intent to utilize a Health Benefit Manager as defined in this contract. Specifically, modify Section I-W to read as follows:

The Contractor shall not delegate any duties or obligations under this Contract to a ~~subcontractor~~ Health Benefit Manager other than a ~~subcontractor~~ Health Benefit Manager named in the bid unless the Contractor has notified the DCH **at least 30 days prior to the Health Benefit Manager contract effective date.** ~~Contract Administrator.~~ DCH reserves the right to disallow the Contractor's use of the ~~subcontractor~~ **Health Benefit Manager.**

Rationale

These changes are intended to clarify the requirements for health plans and DCH with regard to administrative subcontracts and contracts with Health Benefit Managers. The changes are not intended to impose any new requirements on DCH or the plans.

SECTION II CHANGES

3 - Contract Change – Nursing Home Residents and Hospice Services

Modify Section II-D-3 (Medicaid Eligible Groups Excluded From Enrollment in the CHCP) to clarify that persons residing in a nursing home or receiving hospice services on the effective date of enrollment are excluded from enrollment in the MHP. Specifically, add the following as the new fourth bullet in the list under II-D-3:

- **Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan**

Rationale

This contract change is for clarification purposes only. Persons residing in a nursing home or receiving hospice services on the effective date of enrollment are considered an enrollment error. All terms and conditions for enrollment errors under II-F-9 continue to apply to enrollment of persons residing in a nursing home or receiving hospice services on the effective date of enrollment.

4 - Contract Change – Exclusion of Incarcerated Individuals

Modify Section II-D-3 (Medicaid Eligible Groups Excluded From Enrollment in the CHCP) to clarify that persons incarcerated in county, state, or federal correctional facility are excluded from enrollment in the MHP. Specifically, modify the fifth bullet in Section II-D-3 to read as follows:

- **Persons incarcerated in a city, county, state, or federal correctional facility**

Rationale

This contract change is for clarification purposes only. Upon notification, DCH currently disenrolls individuals incarcerated in any correctional facility from the MHP from the date of incarceration.

5 - Contract Change – Newborn notification forms

Amend II-F-7 (Newborn Enrollment) to reflect that the MHP must submit newborn notification forms for out-of-state births and births not captured by the automated enrollment system within 90 days from the date of birth. Also, modify the section to allow an exception for the timeframe in instances where the MHP is not aware that the member has given birth. Specifically, section II-F-7 to read as follows:

At a minimum, newborns are eligible for Medicaid for the month of their birth and may be eligible for up to one year or longer. Newborns of mothers who were eligible and enrolled at the time of the child's birth will be automatically enrolled with the mother's Contractor. The Contractor will be responsible for all covered services for the newborn until notified otherwise by DCH. The Contractor will receive a capitation payment for the month of birth and for all subsequent months of enrollment. Contractors are required to reconcile the plan's birth records with the enrollment information supplied by DCH.

If DCH does not notify the Contractor of the newborn's enrollment within 2 months of the birth **or the child is born outside of Michigan**, the Contractor is responsible for submitting a newborn notification form to DCH. The Contractor must submit the newborn notification form to DCH **within 90 days 6 months of the date of birth or 30 days of notification of the birth, whichever is later. If the Contractor submits the newborn notification form after the deadline the child will be enrolled retroactively for birth month only. DCH will not accept newborn notification forms after six months from date of birth.**

Rationale

As DCH, the health plans, and the hospitals work together to improve the automated newborn enrollment process, the contract must reflect DCH and the plan's responsibilities regarding those newborns that are not captured by the automated process.

6 - Contract Change – Special Disenrollment Effective Date

Modify Section II-F-11(a) (Special Disenrollments) to require that the effective disenrollment date of approved special disenrollment requests is no later than 60 days after the MHP's submission of the special disenrollment request. Specifically, modify the last section of II-F-11(a) to read as follows:

A Contractor may not request special disenrollment based on the physical or mental health status of the enrollee. If the enrollee's physical or mental health is a factor in the violence or noncompliance, the Contractor must document evidence of the Contractor's actions to assist the enrollee in correcting the problem, including appropriate physical and mental health referrals. The Contractor must also document that continued enrollment seriously impairs the Contractor or providers' ability to furnish services to this enrollee or other enrollees. DCH reserves the right to require additional information from the Contractor to assess the appropriateness of the disenrollment. **The effective disenrollment date shall be within 60 days from the date DCH received the complete request from the Contractor that contains all information necessary for DCH to render a decision. If the beneficiary exercises their right of appeal, the effective disenrollment date shall be no later than 30 days following resolution of the appeal.**

Rationale

Special disenrollment requests concern enrollees whose actions are inconsistent with MHP membership—for example, fraud, abuse, or other intentional misconduct—and the MHP is responsible for members until the date of disenrollment. Therefore, this contract change is designed to put a time limit on the length of the enrollee’s continued enrollment in the plan following submission of the MHP’s complete special disenrollment request.

7 - Contract Change – Children’s Special Health Care Services Disenrollment

Modify Section II-F-11(b) (CSHCS Eligibility and Enrollment) to specify that individuals determined eligible for, and subsequently enrolled in, the CSHCS program will be retroactively disenrolled from the MHP back to the beginning of the onset of the beneficiary’s CSHCS-eligible condition. Specifically, the second paragraph of Section II-F-11(b) to read as follows:

If the child is determined medically eligible and if the family decides to enroll in CSHCS, DCH will approve the Contractor’s disenrollment request. The effective date of disenrollment is **either (1) the first of the month of the child’s admission to a facility during which the eligible condition was identified or , (2) the first of month that the Contractor received notification of the child’s eligible condition if the child was not admitted to a facility when the eligible condition was identified. The Contractor or hospital must submit a complete Medical Eligibility Referral Form (MERF) containing all necessary signatures and information required by DCH to determine medical eligibility to DCH within 30 calendar days of admission or Contractor’s receipt of notification of the eligible condition. If the MERF is not submitted within 30 calendar days of the admission or Contractor’s receipt of notification, the effective date of disenrollment will be the first of the month that the Contractor submits the complete MERF. If the family does not choose to enroll in CSHCS, the child will remain in the health plan.**

Rationale

DCH’s current practice of partial retroactive disenrollment of beneficiaries who become enrolled in CSHCS is problematic for providers, the MHPs, and DCH. This contract change will facilitate the provider’s ability to receive payment while maintaining DCH’s current policy retroactively disenrolling beneficiaries upon enrollment in CSHCS.

8 - Contract Change – Innovative Incentive Programs

Modify Section II-G-2 (Enhanced Services) to require the MHPs to develop innovative programs with providers as part of the enhanced services offered by the MHP. Specifically, add a new bullet to Section II-G-2 that reads as follows:

- **Upon request from DCH, collaborate with DCH on projects that focus on improvements and efficiency in the overall delivery of health services**

Also, modify Section II-AA (DCH Responsibilities) to require DCH to assist the MHPs in the development of these special programs. Specifically, add a new bullet in Section II-AA that reads as follows:

- **Participate with Contractors in the design, data collection, and evaluation of system-wide incentive programs to improve access, quality and performance.**

Rationale

The contract language specifically permits MHP’s development of special programs to incentivize improvements in health care delivery systems and contractually binds DCH to participate in the development and evaluation of these special programs.

9 - Contract Change – Substance Abuse Treatment Drugs

Modify Section II-G-3 (Services Covered Outside of the Contract) to specify that substance abuse treatment pharmaceuticals are covered outside of the contract with the MHPs. Specifically, revise the bullet in Section II-G-3 that refers to substance abuse services to read as follows:

- Substance abuse services through accredited providers including:
 - Screening and assessment
 - Detoxification
 - Intensive outpatient counseling and other outpatient services
 - Methadone treatment and other substance abuse pharmaceuticals indicated exclusively for substance abuse treatment and specified on DCH’s pharmacy vendor’s web site under the “Classes for Psychotropic and HIV/AIDs Carve Out” @ www.Michigan.fhsc.com.

Also, revise Section II-H-8(b) to designate substance abuse treatment pharmaceuticals as part of the point-of-service carve out. Specifically, revise Section II-H-8(b) to read as follows:

(b) Pharmacy carve out

The Contractor is not responsible for: (1) anti-psychotic classes and the H7Z class psychotropic drugs as listed under the category “Classes for Psychotropic and HIV/AIDs Carve Out” @ www.Michigan.fhsc.com; (2) drugs in the anti-retroviral classes, as listed under the category “Classes for Psychotropic and HIV/AIDs Carve Out @ www.Michigan.fhsc.com, including protease inhibitors and reverse transcriptase inhibitors; (3) substance abuse treatment drugs as listed under the category “Classes for Psychotropic and HIV/AIDs Carve Out @ www.Michigan.fhsc.com. These medications will be reimbursed by MDCH’s pharmacy TPA, First Health, through a point-of-service reimbursement system.

Rationale

The contract specifies that MHPs are not responsible for substance abuse services. This contract language clarifies that this carve out also applies to substance abuse treatment drugs.

10 - Contract Change – Special Coverage Provisions

Modify the introductory paragraph in Section II-H (Special Coverage Provisions) to clarify the intent of the section. Specifically, remove the bulleted list and modify the introduction to read as follows:

Contractors are required to follow specific coverage and payment policies apply to certain types of for the services and/or providers contained in this section.

Rationale

This contract amendment is for clarification purposes only and does not convey a new requirement.

11 - Contract Change – Emergency Services

Modify section II-H-1(c) (Facility Services) to include the timeframe specified by 42 CFR 438.114 and 42 CFR 422.113. Specifically, modify the final sentence of II-H-1(c) to read as follows:

However, such services shall be deemed prior authorized if the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 **(1 hour)** for responding to a request for authorization being made by the emergency department.

Rationale

Individuals within DCH and MHPs have requested that the timeframe be specified in the contract to facilitate implementation of this subsection. This contract change confers no new responsibilities upon DCH or the MHPs.

12 - Contract Change – Out-of-Network Services

Modify Section II-H-2 (Out-of-Network Services) to clarify that out-of-network service provisions also apply when the enrollee is out of state. Also, modify the Section to clarify that Medicaid fee screens includes specific rates as well as Medicaid policy used to establish special prices. Specifically, modify Section II-H-2 to read as follows:

The Contractor must reimburse non-network providers for covered services if ~~(1) the service was medically necessary, and approved~~ **authorized** by the Contractor, ~~and or (2) if the eCovered services was immediately required and could not reasonably be obtained by a network provider, inside or outside the State of Michigan, on a timely basis. Non-emergent services~~ **Covered services** are considered authorized if the Contractor does not respond to a request for authorization within 24 hours of the request. ~~(but not emergent~~ **Authorization for emergent services are is covered under Section II-H-1) This provision applies to non-network providers inside and/or outside the State of Michigan.**

Out-of-network claims must be paid at established **Michigan** Medicaid fees in effect on the date of service for paying participating Medicaid providers as established by Medicaid policy. **If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid policy for the determination of the correct payment amount.**

Rationale

To facilitate the MHP's ability to work with out-of-state providers, the contract was changed to specifically state that, under contract with the State, MHPs are required to pay according to Michigan Medicaid fee screen rates and policies for services provided to MHP enrollees by out-of-state providers.

13 - Contract Change – Immunizations

Modify section II-H-10 (Immunizations) to reflect Medicaid policy bulletin 04-22 that eliminated the provision of vaccines for adults to local health departments at no cost under the Michigan Vaccine Replacement Program. Specifically, modify section II-H-10 to read as follows.

The Contractor agrees to provide enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. Immunizations should be given in conjunction with Well Child/EPSTD care. The Contractor must encourage that all providers use vaccines available free under the Vaccine for Children (VFC) program for

children 18 years old and younger available at no cost from local health departments. **For vaccines available through the VFC, when the immunization is obtained at a local health department, the Contractor is responsible for the reimbursement of administration fees regardless of prior authorization or the existence of a contract with the local health department.**

For enrollees age 19 year of age or older, Contractors are responsible for the reimbursement of vaccine and administration fees for immunizations **covered by Medicaid policy** that enrollees obtained from local health departments at Medicaid-FFS rates. This policy is effective without Contractor prior authorization and regardless of whether a contract exists between the Contractor and the local health departments.

The Contractor must participate in the local and state immunization initiatives/programs. Contractors must also **educate and encourage** ~~facilitate and monitor~~ provider participation with the **Michigan Care Improvement Registry (MCIR)**. ~~MCIR is a database of child vaccination histories that enables immunization tracking and recall.~~

Rationale

Pursuant to Public Act of 91 of 2005, the name and function of MCIR was modified to expand the scope and improve the utility of the registry.

14 - Contract Change – Transportation Services

Modify section II-H-11(Transportation) to clarify that the Contractor is only required to provide non-emergency transportation to authorized, covered services. Also, modify the section to specify that “travel expenses” for non-emergency transportation includes meals and lodging when appropriate. Specifically, modify section II-H-11 to read as follows:

When necessary, the Contractor must ~~ensure~~ provide non-emergency transportation, **including and travel expenses,** to authorized, covered medical services. ~~The Contractor is only required to provide non-emergency transportation when it is determined to be necessary for enrollees to secure medically necessary medical examinations and treatment.~~ **Travel expenses include lodging and meals as directed under DHS guidelines for the provision of lodging and meals.** Contractors ~~may~~ **must** utilize DHS guidelines for **the determination of necessity and** the provision of non-emergency transportation. DCH will obtain and review Contractor’s non-emergency transportation policies, procedures, and utilization information, upon request, to ensure this requirement is met.

Rationale

The current contract states that MHPs may utilize DHS guidelines for the provision of non-emergency transportation and the DHS guidelines specifically include the provisions covering the determination of necessity and the requirement for the provision of lodging and meals. This contract amendment is for clarification purposes only and does not convey a new requirement.

15 - Contract Change – Restorative Health Services

Modify section II-H-14 (Restorative Health Services) to clarify that MHPs are responsible for providing restorative health services in a nursing facility for up to 45 days within a rolling 12-month period. Specifically, modify the second sentence of section II-H-14 by adding the following phrase, as follows:

The Contractor is responsible for providing up to 45 days (**within a rolling 12 month period from initial admission**) of intermittent or short-term restorative or rehabilitative services in a nursing facility as long as medically necessary and appropriate for enrollees.

Rationale

MHPs have stated that the time period of the 45-day limit on restorative health services is not clear in the current contract. This contract amendment is for clarification purposes only and does not convey a new requirement.

16 - Contract Change – Dental Services

Modify section II-H (Special Coverage Provisions) to describe the scope of MHP responsibility for dental services for members under 21 years of age. Specifically, add a new Section II-H-19 to read as follows:

Dental Services for Members Under 21 Years of Age

The Contractor agrees to act as DCH’s third party administrator and reimburse the contracted dental benefits provider for Medicaid-covered dental services provided to the Contractor’s enrollees under 21 years of age. In the performance of this function:

- 1. The Contractor must follow Medicaid fee-for-service (FFS) policy for utilization and coverage for dental services for beneficiaries under 21 years of age. The Contractor must follow Medicaid FFS policy for prior authorization for dental services for beneficiaries under 21 years of age.**
- 2. The Contractor agrees to provide payment files to DCH in the format and manner prescribed by DCH available at www.michigan.gov/mdch.**
- 3. DCH agrees to use the payment files to reimburse the Contractor according to the Medicaid dental reimbursement policy.**
- 4. The Contractor is responsible for pharmacy services related to dental services for enrollees under 21 years of age.**

Rationale

DCH anticipates that moving dental services from a carved out service provided by Medicaid fee-for-service to a service provided within the contract, where possible, will facilitate MHPs ability to manage the care of these members. The contract language requires MHPs to act as the third party administrator for DCH with regard to dental services and the DCH dental health benefits manager.

17 - Contract Change – Case Management

Add a new subsection to Section II-H (Special Coverage Provision) to clarify that MHPs are required to provide case management services and provide a description of case management services. Specifically, move the final paragraph of II-S-1 and add language to create a new subsection Section II-H-20 to read as follows.

Case Management

The Contractor agrees to provide case management and coordination services. Case management services must be operationally integrated into the Contractor’s utilization management and enrollee services.

The Contractor will demonstrate a commitment to case managing the complex health care needs of enrollees. Commitment will be demonstrated by the involvement of the enrollee in the development of her or his treatment plan and will take into account all of an enrollee's needs (e.g. home health services, therapies, durable medical equipment and transportation) [This paragraph was moved from Section II-S-1]

Rationale

Case management services were discussed in section II-S (Enrollee Services); however, the contract does not specifically describe case management services. This contract amendment is for clarification purposes only and does not convey a new requirement.

18 - Contract Change – Accreditation

Modify section II-K-1 (Administrative and Organizational Criteria) to remove the language regarding different requirements for new and previous contractors and the gap in accreditation. Specifically, revise the fifth and sixth bullets in Section II-K-1 to read as follows:

- Contractors who held a contract with the State of Michigan on September 30, 2003 must hold and maintain accreditation as a managed care organization by the National Committee for Quality Assurance (NCQA), ~~or Joint Commission on Accreditation of Health Care Organizations (JCAHO), or – After October 1, 2004, these Contractors may seek URAC accreditation for Health Plans.~~ The Contractor is allowed one six-month gap over the lifetime of this contract including any contract extensions beyond 2006 if exercised and only if the Contractor is changing from one accrediting organization to another accrediting organization.
- Contractors who did not hold a contract with the State of Michigan on September 30, 2003, must obtain and maintain accreditation, ~~by September 30, 2006,~~ as a managed care organization by the National Committee for Quality Assurance (NCQA), ~~Joint Commission on Accreditation of Health Care Organizations (JCAHO),~~ or URAC accreditation for Health Plans **within 24 months of beginning operations with Medicaid enrollees.**

Rationale

The different requirements for new and previous contractors and the allowance for a gap in accreditation are no longer relevant under the new contract. Additionally, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is no longer providing accreditation for managed care health plans.

19 - Contract Change – Provider Network

Modify section II-K-3 (Provider Network and Health Service Delivery Criteria) to clarify that MHPs must maintain a network of providers accessible to enrollees throughout the plan's approved service area. Specifically, modify the first bullet to read as follows:

- Maintain a network of qualified providers in sufficient numbers and locations **within the counties in the service area, including counties contiguous to the Contractor's service area,** to provide required access to covered services;

Rationale

This contract change is for clarification purposes only. Plans are required to document the existing network each year during the annual on-site visit.

20 - Contract Change – Key Personnel

Modify Section II-L-2 (Administrative Personnel) to clarify that the term “key personnel” applies to the list of positions specified in subsection a through j. Additionally, specify that the Quality Improvement and Utilization Director position may be split into two positions. Specifically,

- Re-order the list to move “Support/Administrative Staff” to the final subsection
- Add the parenthetical phrase “**(listed in subsections a through j below)**” after the words “key personnel” in the introductory paragraph.
- Change II-L-2(c) to read as follows:
The Contractor must provide a full time quality improvement and utilization director who is a Michigan licensed physician, or Michigan licensed registered nurse, or another licensed clinician as approved by DCH based on the plan’s ability to demonstrate that the clinician possesses the training and education necessary to meet the requirements for quality improvement/utilization review activities required in the contract. **The Contractor may provide a quality improvement director and a utilization director as separate positions. However, both positions must be full-time and meet the clinical training requirements specified in this subsection.**

Rationale

Individuals within DCH and MHPs have requested that the term “key personnel” be specified in the contract to facilitate implementation of this subsection. This contract change confers no new responsibilities upon DCH or the MHPs.

21 - Contract Change – Automated Contact Tracking System

Modify section II-L-5 (Management Information System) to indicate that plans are required to utilize BPCT and any contact tracking system subsequently adopted by DCH to submit specified administrative change requests and maternity case rate requests. Specifically, insert a new third paragraph as follows:

The Contractor is required to utilize the Department’s Automated Contact Tracking System (currently, Beneficiary and Provider Contact Tracking System, BPCTS) to submit the following requests:

- **Disenrollment requests for out of area members who still appear in the wrong county on the Contractor’s enrollment file**
- **Request for newborn enrollment for out of state births or births for which DCH does not notify the Contractor of the newborn’s enrollment within 2 months of the birth**
- **Maternity Case Rate Invoice Generation request for out of state births or births for which DCH does not notify the Contractor of the newborn’s enrollment within 2 months of the birth**
- **Other administrative requests jointly developed by DCH and Michigan Association of Health Plans during the term of the Contract**

Rationale

The automation of these requests will reduce processing time and allow easier tracking for both DCH and the health plans.

22 - Contract Change – Primary Care Physician (PCP) Changes

Modify section II-L-7(a) (Provider Network, General) to insert language that allows MHPs to limit the frequency with which the enrollee may change PCPs without cause. Specifically, insert a new third paragraph into section II-L-7(a) to read as follows:

Enrollees shall be provided with an opportunity to change their PCP. The Contractor may not place restrictions on the number of times an enrollee can change PCPs with cause. However, the Contractor may establish a policy that restricts enrollees to PCP changes without cause. The Contractor must receive approval for this policy from DCH.

Rationale

MHPs have requested permission to limit the number of “no cause” PCP changes an enrollee may make. This contract provision will allow these restrictions.

23 - Contract Change – PCP Submission File

Modify Section II-L-7(a) (Provider Network-General) to add the requirement that MHPs submit a PCP Submission File each month. The PCP Submission File includes all PCP assignments for MHP members. MHPs are required to submit at least one audit file per month but may submit changes and additions more frequently. Specifically, add the following paragraph at the end of Section II-L-7(a):

The Contractor will participate in the DCH file process for obtaining Contractor PCP data for dissemination to DCH eligibility and enrollment vendors. The Contractor must submit an initial complete file showing all PCP assignments for the current month prior to the implementation date of this process. Subsequently, the Contractor must submit a full replacement file showing PCP assignments for the following month on the last business day of the month. The Contractor is allowed to submit PCP changes and additions each week during the month to DCH that DCH will send weekly to DCH eligibility and enrollment vendors.

Rationale

Over the years we have been working together, DCH and the MHPs have discussed the importance of a medical home. Making sure members have a relationship with a PCP is central to building this medical home. DCH would like to institute this new method to make PCP information readily available to providers so that they can do their part in directing members to get services from their PCP. Having PCP information available to providers also facilitates referrals and authorizations. Additionally, this process allows DCH to provide a compromise to requiring PCP information on the member identification card.

24 - Contract Change – Provider Network Requirements

Modify Section II-L-7(a) (Provider Network, General) to insert language that clarifies that specialists must be available throughout the plan’s service area. Specifically modify the 2nd and 5th bullets so that Section II-L-7(a) reads as follows:

- The Contractor shall have at least one full-time PCP per 750 members. This ratio shall be used to determine maximum enrollment capacity for the Contractor in an approved service area. Exceptions to the standard may be granted by DCH on a case-by-case basis, for example in rural counties;
- Provides available, accessible, and sufficient numbers of facilities, locations, and personnel for the provision of covered services with sufficient numbers of provider locations with provisions for physical access for enrollees with physical disabilities; **such locations shall be located within the counties in the Contractor's service area, including counties contiguous to the Contractor's service area, to the extent available in the provider community;**
- Has sufficient capacity to handle the maximum number of enrollees specified under this Contract;
- Guarantees that emergency services are available seven days a week, 24-hours per day;
- Provides access to specialists based on the availability and distribution of such specialists. **The Contractor's provider network shall include specialists within the counties in the Contractor' service, including counties contiguous to the Contractor's service area, to the extent available in the provider community.** If the Contractor's provider network does not have a provider available for a second opinion within the network, the enrollee must be allowed to obtain a second opinion from an out-of-network provider with prior authorization from the Contractor at no cost to the enrollee

Rationale

The intent of this contract change is to clarify that specialists may not be located in a single region or area of the State but rather must be distributed throughout the MHP's service area to the extent possible based on availability.

25 - Contract Change – Hospital Payments

Modify Section II-M-7 (Hospital Payments) to incorporate language that enables MHPs to collaborate with DCH and hospitals in the development and implementation of incentive programs. Specifically, add a second paragraph that reads as follows:

Upon request from DCH, Contractors must develop incentive programs for improving access, quality, and performance with both network and out-of-network hospitals. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network hospitals dictated by the methodology jointly developed by the Contractor and DCH.

Rationale

The intent of this contract change is to enable MHPs and DCH to work collaboratively to develop financial incentives for acute care hospitals to contract with the MHPs. The contract language permits MHPs to make incentive payments to hospitals that participate in the programs designed to improve access, quality and performance.

26 - Contract Change – Utilization Management

Modify Section II-P (Utilization Management) to clarify the timeframes for standard and expedited authorization decisions. Specifically, add the phrase “from date of receipt” to the final paragraph in Section II-P so that the final paragraph reads as follows:

The Contractor’s authorization policy must establish timeframes for standard and expedited authorization decisions. These timeframes may not exceed 14 calendar days **from date of receipt** for standard authorization decisions and 3 working days **from date of receipt** for expedited authorization decisions. These timeframes may be extended up to 14 additional calendar days if requested by the provider or enrollee and the Contractor justifies the need for additional information and explains how the extension is in the enrollee’s interest. The enrollee must be notified of the plan’s intent to extend the timeframe. The Contractor must ensure that compensation to **the** individuals or subcontractor that conduct utilization management activities is not structured so as to provide incentives for the individual or subcontractor to deny, limit, or discontinue medically necessary services to any enrollee.

Rationale

This contract change is for clarification purposes only.

27 - Contract Change – Marketing and Incentives

Modify Section II-R-4 (Marketing Materials) to specify that if an MHP has previously received DCH approval for marketing material or an incentive program and wishes to utilize the marketing or incentive program again, the DCH approval process may be streamlined. Specifically, modify the first paragraph of Section II-R-to read as follows:

All written and oral marketing materials and health promotion incentive materials must be prior approved by DCH. Upon receipt by DCH of a complete request for approval that proposes allowed marketing practices and locations, the DCH will provide a decision to the Contractor within 30 business days or the Contractor’s request will be deemed approved. **If DCH has previously approved the Contractor’s marketing material or an incentive program, the Contractor may request expedited approval. The Contractor must submit a copy of the material or incentive program and attest that none of the aspects of the marketing or incentive have changed. DCH will provide a decision within 10 calendar days or the Contractor’s expedited request will be deemed approved.**

Rationale

DCH provides a similar review process for health education materials. Additionally, since DCH has already reviewed the marketing or incentive materials, DCH can provide an expedited to review. The expedited review process decreases lead time required by the MHP for implementation of marketing or incentives previously approved by DCH.

28 - Contract Change – Reading Level

Modify Sections II-R-4 (Marketing Materials) and II-S (Enrollee Services) to clarify the required reading level for written material distributed to MHP enrollees. Specifically, modify the introduction to section II-S and section II-S-3 as follows:

- Modify the first sentence in the fourth paragraph as follows: Materials must be written at no higher than ~~6th~~ **6.9** grade **reading** level as determined by any one of the following indices:

- Modify the third sentence in the introductory paragraph as follows: These materials must be written ~~below the sixth~~ **at no higher than 6.9** grade reading level.
- Modify the first sentence following the bulleted list in Section II-S-3 as follows: The handbook must be written at no higher than ~~a sixth~~ **6.9** grade reading level and must be available in alternative formats for enrollees with special needs.

Rationale

This contract change is for clarification purposes only. DCH requires all marketing materials and required member materials (handbook, directory, letters, etc.) to be written at no higher than 6th grade reading level, which includes 6.9 reading level. DCH does permit certain health education materials for members to exceed 6.9 reading level due to the technical language; however, with technical language removed, the written materials must be no higher than 6.9 reading level.

29 - Contract Change – Member Identification Cards

Modify Section II-S-1 (Enrollee Services – General) to provide a mechanism for plans to be exempt from the requirement to place PCP information on the member identification cards. If the MHP provides weekly updates—including changes and additions—to the PCP Submission File, the MHP will not be required to place PCP information on the membership identification card. Specifically, add the following paragraph to the end of Section II-S-1:

The Contractor may submit a weekly PCP Submission Update File that includes all PCP changes and additions made by the Contractor during that week. If the Contractor submits an update file each week, the Contractor is not required to include the member’s PCP name and phone number on the member identification card.

Rationale

PCP information must be readily available to the providers and the members. Access to PCP information can be accomplished by listing the information on the membership identification card or by providing accurate and up-to-date information to DCH’s eligibility and enrollment vendors.

30 - Contract Change – Grievance and Appeals

Modify II-T-1 (Contractor Grievance/Appeal Procedure Requirements) to remove the incorrect legal reference and incorporate the consensus reached between DCH and OFIS. Specifically, modify II-T-1 to read as follows:

II-T GRIEVANCE/APPEAL PROCEDURES

The Contractor will establish and maintain an internal process for the resolution of grievances and appeals from enrollees. Enrollees may file a grievance or appeal on any aspect of service provided to them by the Contractor as specified in the definitions of grievance and appeal.

1. Contractor Grievance/Appeal Procedure Requirements

The Contractor must have written policies and procedures governing the resolution of grievances and appeals. These written policies and procedures will meet the following requirements:

- (a) **Except as specifically exempted in this section**, the Contractor shall administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 - 438.424 (Subpart F) and MCL 550.1404.
- (b) **The Contractor shall** cooperate with the Michigan Office of Financial and Insurance Services in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act."
- (c) **The Contractor shall make a decision on non-expedited grievances or appeals within 35 days of receipt of the grievance or appeal. This timeframe may be extended up to 10 business days if the enrollee requests the extension or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the enrollee's interest. If the Contractor utilizes the extension, the Contractor must give the enrollee written notice of the reason for the delay. The Contractor may not toll (suspend) the time frame for grievance or appeal decisions other than as described in this section.**
- (d) **If a grievance or appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the beneficiary, the 35-day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the beneficiary that an authorized representative form or document is required. For purposes of this section "third party" includes, but is not limited to, health care providers.**
- (e) The Contractor's internal grievance and appeal procedure must include the following components:
 - **The Contractor shall allow enrollees 90 days from the date of the adverse action notice within which to file an appeal under the Contractor's internal grievance and appeal procedure.**
 - The Contractor must give enrollees assistance in completing forms and taking other procedural steps. The Contractor must provide interpreter services and TTY/TDD toll free numbers.
 - The Contractor must acknowledge receipt of each grievance and appeal.
 - The Contractor must ensure that the individuals who make decisions on grievances and appeals are individuals who are:
 - (1) ~~Who were~~ Not involved in any previous level of review or decision-making, and;
 - (2) ~~Who are~~ Health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease, when the grievance or appeal involves a clinical issue.

Additionally, modify II-T-5 (Expedited Appeal Process) to read as follows:

5. Expedited Appeal Process

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

- The enrollee or provider may file an expedited appeal either orally or in writing.

- The enrollee or provider must file a request for an expedited appeal within ~~10~~ **90** days of the adverse determination.
- The Contractor will make a decision on the expedited appeal within ~~3 working days~~ **72 hours** of receipt of the expedited appeal. ~~This timeframe may be extended up to 10 calendar days~~ If the enrollee requests ~~the an~~ extension, or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the enrollee's interest. ~~If the Contractor utilizes the extension,~~ **should transfer the appeal to the standard 35-day timeframe and give the enrollee written notice of the transfer within 2 days of the extension request.**
- The Contractor will give the enrollee oral and written notice of the appeal review decision.
- If the Contractor denies the request for an expedited appeal, the Contractor will transfer the appeal to the standard 35-day timeframe and give the enrollee written notice of the denial within 2 days of the expedited appeal request.
- The Contractor will not take any punitive actions toward a provider who requests or supports an expedited appeal on behalf of an enrollee.

Rationale

During the previous contract term, OFIS and DCH reviewed federal and state law regarding grievance and appeal requirements for MHPs. As a result, the two state agencies discussed possible and actual discrepancies between the laws and reached consensus on the requirements for the MHPs. These contract changes reflect the consensus reached by OFIS and DCH.

31 - Contract Change – Encounter Data Reporting

Modify Section II-W-2 (Encounter Data Submission) to indicate that MHPs must submit financial data as part of the encounter data submission. Specifically, modify the first paragraph of II-W-2 to read as follows:

The Contractor must submit encounter data containing detail for each patient encounter reflecting services provided by the Contractor. Encounter records will be submitted monthly via electronic media in a HIPAA compliant format as specified by DCH that can be found at www.michigan.gov/mdch.

Submitted encounter data will be subject to quality data edits prior to acceptance into DCH's data warehouse. The Contractor's data must pass all required data quality edits in order to be accepted into DCH's data warehouse. Any data that is not accepted into the DCH data warehouse will not be used in any analysis, including, but not limited to, rate calculations, DRG calculations, and risk score calculations. DCH will not allow Contractors to submit incomplete encounter data for inclusion into the DCH data warehouse and subsequent calculations.

Stored encounter data will be subject to regular and ongoing quality checks as developed by DCH. DCH will give the Contractor a minimum of 60 days notice prior to the implementation of new quality data edits; however, DCH may implement informational edits without 60 days notice. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by DCH (See Appendix 4). The Contractor must participate in regular data quality assessments conducted as a component of ongoing encounter data on-site activity.

is intended to address data sharing, cooperation on primary care and specialty capacity development, care management, continuity of care, quality assurance, and other future items that may be identified by MDCH. A model MOA will be developed by the MDCH in cooperation with DWCHA and the Wayne county Contractors.

Rationale

At this time, DCH will only require a model MOA for health plans upon request.

35 - Contract Change – Report Grid

Modify Appendix 3 (Reporting Requirements for Medicaid Health Plans) to reflect the correct due dates for reports. Specifically, the following changes are reflected in the revised reporting grid:

- **All dates have been revised to reflect the new contract year**
- **The Quality Improvement Plan Annual Evaluation and Work Plan is due on June 30 instead of July 30 and should be submitted in electronic format.**
- **DCH has changed the form for Physician Incentive Program (PIP) Reporting from the CMS annual update form to the DCH's PIP Attestation form and PIP Disclosure forms.**

Rationale

The contract change updates reporting requirements and timelines. No new reporting requirements have been added; the change in the due date for the Quality Improvement Plan Annual Evaluation and Work Plan is necessary to facilitate DCH's incorporation of these reports in DCH's External Quality Review process.

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

August 31, 2006

**CHANGE NOTICE NO. 7
 TO
 CONTRACT NO. 071B5200007
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075	TELEPHONE (248) 559-5656 Chris Scherer
Csherer@glhp.com	BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT with three 1 year renewal options <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 September 1, 2006, Attachment B – Approved Service Area is amended to add Branch, Kalamazoo, and St. Joseph to Region 3. All other terms, conditions, specifications and pricing remain unchanged.

Note: Buyer is changed to Kevin Dunn (517) 241-4225.

AUTHORITY/REASON:

Per DCH e-mail dated 8/9/06 and DMB/Purchasing Operations approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$157,894,736.00

FOR THE VENDOR:

Great Lakes Health Plan Inc.

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

FOR THE STATE:

 Signature

Sean L. Carlson

 Name

Director, Acquisition Services

 Title

 Date

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 16, 2006

CHANGE NOTICE NO. 6
TO
CONTRACT NO. 071B520007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 559-5656
Great Lakes Health Plan Inc. 17117 West Nine Mile Road, Suite 1600 Southfield, MI 48075 Csherer@glhp.com		Chris Scherer
		BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933		
Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 2, 3, 7, 9, 10 – DCH		
CONTRACT PERIOD: From: October 1, 2004		To: October 1, 2006
TERMS	SHIPMENT	with three 1 year renewal options
N/A		N/A
F.O.B.	SHIPPED FROM	
N/A		N/A
MINIMUM DELIVERY REQUIREMENTS		
N/A		

NATURE OF CHANGE (S):

Please note, effective immediately the attached sub-contract agreement with Access2Care is hereby incorporated into this Contract. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

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

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$157,894,736.00

Great Lakes Health Plan

Purchasing Operations

Medical Transportation Services Agreement

This Medical Transportation Services Agreement (this "Agreement") is entered into by and between Great Lakes Health Plan, Inc., (referred to as either "GLHP" or "Payor") and _____ (referred to as either "Transportation Vendor").

RECITALS

Payor is a prepaid comprehensive health care plan qualified to carry on such business in the Payor has entered into a contract with the State of Michigan pursuant to which Payor has agreed to provide and operate comprehensive prepaid health service plans to enrolled Medicaid recipients and provides and operates such plans under the collective product name of Great Lakes Health Plan, Inc.; and

Payor has contractual arrangements with physicians, health care professionals, hospitals, and other medical vendors and has as its primary objective to arrange for and facilitate the provision and delivery of health services to Covered Members (as hereinafter defined);

Transportation Vendor is in the business of arranging for and managing a network of medical transportation service companies (Vendors) to provide non-emergency, non-ambulance, ground transportation services to Medically Necessary appointments of all Payor's Medicaid Members.

GLHP wishes to arrange to make Transportation Vendor's services available to Members. Transportation Vendor wishes to provide such services, under the terms and conditions set forth in this Agreement.

This Agreement is effective on _____

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained herein, Transportation Vendor and Payor agree as follows:

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 “Affiliates” are those entities controlling, controlled by, or under common control with GLHP.

1.2 “Administrative Guide” or “Provider Manual” A manual of policies, procedures, and administrative practices applicable to persons enrolled through GLHP in a Government-Sponsored Program, published and amended from time to time by GLHP and made available to Transportation Vendor. The provisions of the Provider Manual are incorporated by reference into this Agreement.

1.3 “Benefit Plan” means a certificate of coverage, summary plan description, government contract, or other document or agreement, whether delivered in paper, electronic, or other format, under which GLHP is obligated to provide coverage of Covered Services for a Member. For the purposes of this Agreement, the term Benefit Plan shall specifically include a Government-Sponsored Program and the contract between GLHP and the sponsor of such Program.

1.4 “Capitation Fee” means the amount per Covered Member per month payable to Transportation Vendor in consideration for rendering Covered Transportation Services pursuant to this Agreement.

1.5 “Coverage Agreement” means the policy, contract or certificate entered into or issued by Payor or any affiliate entitling Covered Members to Covered Services. The Coverage Agreement to which this Medical Transportation Services Agreement shall apply shall be the Michigan Medicaid HMO benefit plans in the Service Area.

1.6 “Covered Member” means any person entitled to Covered Services under the terms of one or more Coverage Agreements. Covered Members specifically include the enrollees under the Payor’s Medicaid contract with the State of Michigan.

1.7 “Covered Service” means any non-emergency, non-ambulance, medical related ground transportation service that Payor is obligated to provide to Covered Members pursuant to the terms of a Coverage Agreement.

1.8 “Debarred” has the meaning set forth in Section 9.18 of this Agreement.

1.9 “Effective Date” refers to the date set forth on page 1 of this Agreement.

1.10 “Government-Sponsored Program” means Medicaid programs offered by GLHP.

1.11 “Medicaid” means the joint federal and state administered program which provides medical and other services to persons covered under Title XIX of the Social Security Act, other indigent individuals, uninsured individuals, or other individuals as designated by the State Medicaid Agency.

1.12 “Medically Necessary” means those health care services to which a Member is entitled under the terms of the Medicaid Managed Care Program and the Medicaid Contract which are determined to be (1) necessary for the symptoms, diagnosis and treatment of the condition, disease, ailment or injury; (2) consistent with the standards of good medical practice within the surrounding community; (3) not primarily for the convenience of the Member; and (4) the most appropriate level of service which can safely be provided to the Member.

1.13 “Member” is a person eligible and enrolled or assigned to receive coverage from GLHP for Non-emergent Transportation Services, including such person’s eligible dependants.

1.14 “Transportation Vendor Guidelines” means the quality assurance and improvement program established by Transportation Vendor for review and monitoring of the Transportation Vendor network to assure the proper level and quality of service is provided, and referenced as Appendix 6 to this Agreement.

1.15 “Transportation Vendor Services” are those medical transportation services specified in Appendix 2 of this Agreement that Transportation Vendor shall arrange to be provided to Covered Members.

1.16 “Non-Emergency Medical Transportation Services” means non-emergency, non-ambulance, ground transportation services for routine and urgent appointments to clinics, physician’s offices, outpatient facilities, dental clinics, hospitals and other medically necessary services for eligible Members who do not have the ability to provide their own transportation to and from Covered Services.

1.17 “Non-Emergency Ambulance Medical Transportation Services” means ambulance transportation services arranged under separate financial arrangements as may be described in Appendix 3 for person who have, or predictably will have need for, attendant medical care during routine transfers and non-emergent medical appointments to clinics, physician’s offices, outpatient facilities, hospitals, and other Medically Necessary Services, including hospital discharges.

1.18 “Participating Provider” means a hospital, a physician or any other healthcare provider or entity that has a direct or indirect contractual arrangement with Payor to provide Covered Services to Medicaid enrollees under the relevant State administered contracts between GLHP and the State of Michigan.

1.19 “Protocols” are the programs, protocols and administrative procedures adopted by GLHP to be followed by Transportation Vendor in providing services and doing business with GLHP under this Agreement, specified in Appendix 3 to this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, quality assurance, utilization management, personal care management, case management, quality improvement, peer review, Member grievance, concurrent review, or other similar GLHP programs. The Protocols include but are not limited to those set forth in this Agreement and may change from time to time in accordance with this Agreement. As discussed in Section 4.6 of this Agreement, the Protocols may be made available to Transportation Vendor through the Provider Manual or through other written or electronic communications, all of which shall be incorporated by reference into this Agreement.

1.20 “Service Area” means the service area authorized under Payor’s certificate of authority

from the State of Michigan, as expanded or amended from time to time. As of the Agreement Effective Date, the Service Areas include the designated counties in the State of Michigan as set forth in Appendix 3 to this Agreement.

1.21 “Transportation Cost” means the actual amount paid by Transportation Vendor directly to the Transportation Vendors.

1.22 “Stretcher Services” means transportation using a stretcher provided for patients who require a lying down position, but who do not require, or have predictable need for, attendant medical care during routine transfer to non-emergent medical appointments to clinics, physician’s offices, outpatient facilities, hospitals, other Medically Necessary Services, and hospital discharges.

1.23 “Urgent” or “Urgent Request” means a non-emergency, medically necessary but unscheduled request to be transported to medical services promptly, usually with three (3) to twenty-four (24) hours advance notice.

1.24 “Vendor” means a medical transportation service company/provider under contract with Transportation Vendor.

Article II.
Representations and Warranties

2.1 Representations and Warranties of Transportation Vendor. Transportation Vendor, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) Transportation Vendor is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization; Transportation Vendor is duly qualified to do business as a foreign corporation, limited liability company or limited partnership and in good standing in each other jurisdiction, if any, in which the character of the properties owned or leased by it or the nature of the business conducted by it makes such qualification necessary, except where the failure to be so qualified and in good standing will not have a material adverse effect on it.

(b) Transportation Vendor has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Transportation Vendor have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Transportation Vendor and (assuming the due authorization, execution and delivery of this Agreement by GLHP) constitutes a valid and binding obligation of Transportation Vendor, enforceable against Transportation Vendor in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

(c) The execution, delivery and performance of this Agreement by Transportation Vendor do not and will not violate or conflict with (i) the organizational documents of Transportation Vendor, (ii) any material agreement or instrument to which Transportation Vendor

is a party or by which Transportation Vendor or any material part of its property is bound, or (iii) applicable law.

(d) Transportation Vendor has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

(e) Transportation Vendor has been given an opportunity to review the Protocols, including without limitation those set forth in the Provider Manual, and Payment Policies and acknowledges that it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies.

(f) Each submission of a claim by Transportation Vendor pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to GLHP that (i) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (iii) the charge amount set forth on the claim is the Customary Charge or the amount negotiated under this Agreement and (iv) the claim is a valid claim.

2.2 Representations and Warranties of GLHP. GLHP, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) GLHP is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization; GLHP is duly qualified to do business as a foreign corporation, limited liability company or limited partnership and in good standing in each other jurisdiction, if any, in which the character of the properties owned or leased by it or the nature of the business conducted by it makes such qualification necessary, except where the failure to be so qualified and in good standing will not have a material adverse effect on it.

(b) GLHP has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by GLHP have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by GLHP and (assuming the due authorization, execution and delivery of this Agreement by Transportation Vendor) constitutes a valid and binding obligation of GLHP, enforceable against GLHP in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

(c) The execution, delivery and performance of this Agreement by GLHP do not and will not violate or conflict with (i) the organizational documents of GLHP, (ii) any material agreement or instrument to which GLHP is a party or by which GLHP or any material part of its property is bound, or (iii) applicable law.

(d) GLHP has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Transportation Vendor's Services. This Agreement applies to Transportation Vendor's non-emergent transportation service types set forth in Appendix 1.

3.2 Benefit Plan Types. GLHP Members and those of GLHP's Affiliates may access Transportation Vendor's services under this Agreement for the Benefit Plan types described in Appendix 1. Appendix 1 may be modified by GLHP (including the addition or deletion of Benefit Plans) upon thirty days written or electronic notice to Transportation Vendor.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Transportation Vendor may seek and collect payment from a Member for such services to the extent permitted by law, provided that the Transportation Vendor first obtain the Member's written consent.

This section does not authorize Transportation Vendor to bill or collect from Members for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in Sections 6.7 and 6.11 of this Agreement.

3.4 Patients who are not Members. This Agreement does not apply to services rendered to patients who are not Members at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid.

3.5 Communication with Members. Nothing in this Agreement is intended to limit Transportation Vendor's right or ability to communicate fully with a Member and the Member's physician regarding the Member's health condition and transportation needs.

Article IV.
Duties of Transportation Vendor

4.1 Provide Covered Services. Transportation Vendor will provide Covered Services to Member.

4.2 Transportation Vendor Services. Commencing on the Effective Date, Transportation Vendor agrees to arrange for the provision of Transportation Vendor Services to Covered Members through the Vendors it selects. Transportation Vendor will comply with the Health Plan Transportation Protocol described in Appendix 3 to provide such services. Transportation Vendor Services shall be available twenty-four (24) hours a day, seven (7) days a week. Payor understands and agrees that Transportation Vendor will arrange for the least costly, available means of transporting Covered Members and two escort/companion/attendants while still assuring that such means of transporting are appropriate for the Covered Member.

4.3 Nondiscrimination. Transportation Vendor will, and shall require that Vendor will, not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Member.

4.4 No Discrimination. Transportation Vendor shall not, and shall ensure that Vendor shall not discriminate or differentiate in the treatment of Covered Members based on sex, marital status, age, race, color, national origin, religion, ancestry, physical disability/handicap, medical condition, mental condition, education, political affiliation, personal appearance, source of income, place of residence, veteran status or sexual orientation, and to render services to Covered Members in the same manner and in accordance with the same standards as offered to other passengers.

4.5 Accessibility. Transportation Vendor will, and shall require that Vendor will, maintain the access standards set forth in Appendix 2 and 4.

4.6 Cooperation with Protocols. Transportation Vendor will, and shall require that Vendor will, cooperate with and be bound by GLHP's Protocols. The Protocols include but are not limited to all of the following:

1. Transportation Vendor will provide notification and seek prior authorization for certain Covered Services as defined by GLHP when such notification and/or prior authorization is required by GLHP.
2. Accept and return telephone calls from GLHP's staff within one business day of receiving the call.

The Protocols will be available to Transportation Vendor on-line or upon request. Some or all Protocols also may be made available to Transportation Vendor in the form of an administrative manual or guide or in other written or electronic communications. GLHP may change the Protocols from time to time. GLHP will use reasonable commercial efforts to inform Transportation Vendor at least thirty days in advance of any material changes to the Protocols.

4.7 Employees and subcontractors. Transportation Vendor will assure that its employees, affiliates and any individuals or entities subcontracted by Transportation Vendor to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Transportation Vendor's obligations and accountability under this Agreement with regard to such services.

4.8 Transportation Vendor Guidelines. Commencing on the effective date, Transportation Vendor shall perform and cause Vendors to comply with the Transportation Vendor Guidelines, the Vendor quality assurance and improvement program.

4.9 Vendors. The Vendors shall be selected by Transportation Vendor subject to Transportation Vendor's selection criteria based upon Vendor's ability to comply with the Transportation Vendor Guidelines. Payor shall have the right to review and approve Transportation Vendor's selection criteria prior to execution of this Agreement, which approval shall not unreasonably be withheld. Payor shall have the right to review the Vendors for compliance with Payor's own selection criteria. Payor shall have the right to disapprove of any Vendor, provided that such right shall be exercised reasonably. Transportation Vendor shall use its Best Efforts to ensure that all Vendors perform in accordance with Transportation Vendor's Guidelines.

4.10 Licensure. Transportation Vendor will maintain, and shall require that Vendor will maintain, without material restriction, such licensure, registration and permits as are necessary to enable Transportation Vendor to lawfully perform this Agreement and shall provide to GLHP a

copy of any required documents. . Transportation Vendor shall also require that all Vendors employed by or under contract with Transportation Vendor to render Covered Services to Members comply with this provision.

4.11 Liability Insurance. Transportation Vendor shall, and shall require that Vendor shall, procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Transportation Vendor's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Transportation Vendor's liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Transportation Vendor shall submit to GLHP in writing evidence of insurance coverage. Transportation Vendor shall also require that all Vendors employed by or under contract with Transportation Vendor to render Covered Services to Members procure and maintain commercial general and/or umbrella liability insurance consistent with Transportation Vendor Guidelines.

4.12 Notice. Transportation Vendor will, and shall require that Vendor will, give written notice to GLHP within 10 days after any event that causes Transportation Vendor to be out of compliance with Sections 4.10 or 4.11 of this Agreement, or of any change in Transportation Vendor's name, ownership, control, or Taxpayer Identification Number. In addition, Transportation Vendor will give written notice to GLHP 45 days prior to the effective date of changes in existing remit address(es) and other demographic information. This section does not apply to changes of ownership or control that result in Transportation Vendor being owned or controlled by an entity with which it was already affiliated prior to the change.

4.13 Rules and Regulations. Transportation Vendor shall comply with any rules and regulations of Payor and with any quality assurance plans and procedures of Payor; provided, however, that such rules and regulations and plans and procedures are communicated in writing to Transportation Vendor and agreed upon prior to execution of this Agreement. In the event of a conflict between such rules and regulations or plans and procedures and this Agreement, this Agreement shall govern.

4.14 Grievance Procedures. Transportation Vendor shall, and shall require that Vendors shall, cooperate and participate in the grievance procedures and appeals processes established by Payor and the Medicaid Managed Care Program. Such grievance procedures shall be communicated in writing to Transportation Vendor, and agreed upon prior to execution of this Agreement.

4.15 Member consent for release of medical record information. Transportation Vendor will, and shall require that Vendor will, obtain any Member consent required in order to authorize Transportation Vendor to provide access to requested information or records as contemplated in Section 4.17 of this Agreement, including copies of the Transportation Vendor's medical records relating to the care provided to Member.

4.16 Program Records. Transportation Vendor shall, and shall require that Vendor shall, maintain such records and such information as may be necessary for the evaluation of the quality, appropriateness and timeliness of such services performed under this Agreement and necessary for compliance by Payor with State and Federal laws and regulations. Transportation Vendor will further provide to Payor and, if required, to authorized State or Federal agencies, access to such records of Covered Members as is needed to conduct fiscal audits, medical audits, medical

reviews, utilization reviews and other periodic monitoring upon request by Payor or appropriate governmental agencies.

4.17 Maintenance of and Access to Records. Transportation Vendor will, and shall require that Vendor will, maintain adequate medical, financial and administrative records related to Covered Services rendered by Transportation Vendor under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Transportation Vendor will provide access to these records as follows:

- i) to GLHP or its designees, in connection with GLHP's utilization management, personal care management, case management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Transportation Vendor's compliance with the terms and provisions of this Agreement. Transportation Vendor will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a GLHP audit involving a fraud investigation or the health and safety of a Member (in which case, access shall be given within 48 hours after the request) or of an expedited Member appeal or grievance (in which case, access will be given so as to enable GLHP to reasonably meet the timelines for determining the appeal or grievance); and
- ii) to agencies of the government, in accordance with applicable law, to the extent such access is necessary to comply with regulatory requirements applicable to Transportation Vendor, or GLHP.

Transportation Vendor will cooperate with GLHP on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an audit exit interview within thirty days of GLHP's request.

If such information and records are requested by GLHP, Transportation Vendor shall, and shall require that Vendor will, provide copies of such records free of charge.

4.18 Reports. Transportation Vendor shall provide month-end reports in the form of 1) Monthly Summary Reports, 2) Trip Detail data file, 3) HCFA 1500 Encounter (version 1.04) on electronic media, and 4) other standard reports set forth in Appendix 2 and 4.

4.19 Access to Data. Transportation Vendor will collect and provide to GLHP aggregate, de-identified quality data relating to services rendered by the Transportation Vendor for GLHP's use.

4.20 Compliance with law. Transportation Vendor will, and shall require that Vendor will, comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Member medical information. Transportation Vendor agrees specifically to comply in all relevant respects with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations, in addition to applicable state laws and regulations.

4.21 Electronic connectivity. Transportation Vendor will communicate with GLHP electronically. This may include, among other things, checking Member eligibility status, filing claims, and checking on the status of a claim.

4.22 Responsibility for Damages. Transportation Vendor shall, and shall require that Vendor will, be responsible for any and all damages, claims, liabilities or judgments which may arise as a result of its own negligence or intentional wrongdoing. Any costs for damages, reasonable attorneys fees, claims, liabilities or judgments incurred at any time by GLHP or its affiliates (the "Indemnitee") as a result of the negligence or intentional wrongdoing of Transportation Vendor (the "Indemnitor") or its Vendors or employees shall be paid for or reimbursed by the Indemnitor. This provision shall survive the termination of this Agreement.

4.23 Transportation Vendor/GLHP Coordinator. Transportation Vendor shall appoint a coordinator who shall assume the day-to-day responsibilities with regard to Transportation Vendor's performance under this Agreement and serve as the primary liaison with GLHP. The coordinator shall also assist GLHP or Payor in responding promptly to Member complaints and grievances, and assist GLHP or Payor in resolving all other Member issues that arise in connection with this Agreement.

4.24 Non-Covered Services Discount: For transportation services to which this Agreement applies, but are not covered under the Member's Benefit Plan and for which no other insurance coverage for that Member is available, Transportation Vendor may if it fully informs the Member of the charge prior to rendering the service and to the extent permitted by law, collect from the Member charges for services rendered. However, Transportation Vendor agrees to bill the Member the lesser of the Customary Charge or the amounts for such transportation services set forth in the applicable payment appendix to this Agreement. Transportation Vendor understands and agrees that any transportation services provided to the Member pursuant to this Section shall be paid for directly by the Member and not GLHP or other Payor.

Article V. **Duties of GLHP**

5.1 Payment of Claims. As described in further detail in Article VI of this Agreement, GLHP, will pay Transportation Vendor for rendering Covered Services to Members.

GLHP will make its Payment Policies available to Transportation Vendor GLHP upon request. GLHP may change its Payment Policies from time to time. In the event that GLHP materially changes a Payment Policy, GLHP will make information available to Transportation Vendor describing the change.

5.2 Liability Insurance. GLHP will procure and maintain professional and general liability insurance and other insurance, as GLHP reasonably determines may be necessary, to protect GLHP and GLHP's employees against claims, liabilities, damages or judgments that arise out of services provided by GLHP or GLHP's employees under this Agreement.

5.3 Licensure. GLHP will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable GLHP to lawfully perform this Agreement.

5.4 Notice. GLHP will give written notice to Transportation Vendor within 10 days after any event that causes GLHP to be out of compliance with Section 5.2 or 5.3 of this Agreement, or of any change in GLHP's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in GLHP being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law. GLHP will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Member medical information.

5.6 Electronic connectivity. GLHP will use reasonable commercial efforts to communicate with Transportation Vendor electronically.

5.7 Responsibility for Damages. GLHP shall be responsible for any and all damages, claims, liabilities or judgments which may arise as a result of its own negligence or intentional wrongdoing. Any costs for damages, reasonable attorneys fees, claims, liabilities or judgments incurred at any time by Transportation Vendor (the "Indemnitee") as a result of the negligence or intentional wrongdoing of GLHP (the "Indemnitor") or its employees shall be paid for or reimbursed by the Indemnitor. This provision shall survive the termination of this Agreement.

Article VI.

Submission, Processing, and Payment of Claims

6.1 Administration of Claims. Transportation Vendor shall be responsible for the administration and payment of Vendor claims. Commencing on the Effective Date, Transportation Vendor shall pay, at Transportation Vendor's expense, claims for Transportation Vendor Services provided by Transportation Vendor Vendors. Actual cost of transportation may be subsequently billed to Payor by Transportation Vendor if so stated elsewhere in this Agreement and/or related schedules or attachments.

6.2 Form and content of claims. Transportation Vendor must submit claims for Covered Services in a manner and format prescribed by GLHP, as further described in the Protocols. Unless otherwise directed by GLHP, Transportation Vendor shall submit claims using current CMS 1500 (formerly HCFA 1500) or UB92 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD-9-CM, CPT, Revenue and HCPCS coding. Transportation Vendor shall include in a claim the Member number, Customary Charges or charges negotiated under this Agreement for the Covered Services rendered to a Member during a single instance of service for which the claim is submitted or admission, as applicable, Transportation Vendor's Federal Tax I.D. number and/or other identifiers requested by GLHP.

6.3 Electronic filing of claims. Transportation Vendor will submit all claims covered under this Agreement electronically in accordance with GLHP protocols. In the event the Centers for Medicare and Medicaid Services, in administering the fee-for-service Medicare program, adopts a paper claim user fee, this Agreement will incorporate the same approach, effective on the same date as it becomes effective for the fee-for service-Medicare program.

6.4 Time to file claims. To the extent applicable, all information necessary to process a claim must be received by GLHP no more than 90 days from the date Covered Services are rendered except as otherwise required or permitted in accordance with GLHP Protocols.

In the event GLHP requests additional information in order to process the claim, Transportation Vendor will provide such additional information within 90 days of GLHP's request. In the event such information is timely submitted but is not received within the original timely filing period described in the preceding paragraph, the automated claims processing system might not recognize the claim as timely; in such cases, Transportation Vendor can submit such claims through the appeal process and GLHP will recognize them as timely. Payment of such claims will be determined in accordance with GLHP's Payment Policies.

If GLHP is not the primary Payor, and Transportation Vendor is pursuing payment from the primary Payor, the 90-day filing limit will begin on the date Transportation Vendor receives the claim response from the primary Payor. If Medicare is the primary Payor, a Medicare explanation of benefits must be provided by Transportation Vendor at the time the claim is submitted to GLHP.

6.5 Payment of claims. Payor will pay claims for Covered Services in the amount set forth in the applicable payment appendix to this Agreement, and in accordance with the Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Member's Benefit Plan and applicable law.

6.6 Compensation. As compensation to Transportation Vendor, Payor shall pay to Transportation Vendor the applicable Fees as set forth in Appendix 2 for each Covered Member for which Payor receives capitation payments under the State's Michigan Medicaid and Medicare Programs.

6.7 Denial of claims for not following Protocols or not filing timely. Payment to Transportation Vendor may be denied if Transportation Vendor does not comply with the Protocols or does not file a timely claim under Section 6.4 of this Agreement.

In the event that payment of a claim is denied for lack of notification, failure to seek prior authorization or for untimely filing, GLHP will consider the claim for payment and will not deny it on the grounds of lack of required notification or timely filing if Transportation Vendor appeals within 12 months after the date of service and can show all of the following:

- i) that, at the time the Protocols required notification or at the time the claim was due, Transportation Vendor did not know and was unable to reasonably determine that the patient was a Member;
- ii) that Transportation Vendor took reasonable steps to learn that the patient was a Member; and
- iii) that Transportation Vendor promptly provided notification, sought prior authorization, or filed the claim, after learning that the patient was a Member.

6.8 Verification of Member Coverage and Participating Provider Eligibility. Payor shall make available Covered Member and Participating Provider eligibility data to Transportation Vendor at least two (2) weeks prior to commencement of this contract. Such information shall be made available at least once a month thereafter. This information will be contained in two (2) electronically submitted data files in a comma-delimited format as prescribed by Transportation Vendor. The files shall contain information sufficient to allow Transportation Vendor to determine a Covered Member's eligibility to receive transportation services to an approved medical provider. As a minimum but not limited to, the Covered Member eligibility file will contain member last name, first name, date of birth, Medicaid and/or Insured's identification number, street address, city, state, zip code, enrollment date and disenrollment date. The Participating Provider eligibility file will contain, as a minimum but not limited to, last name, first name, street address of practice setting, city, state, and zip code.

6.9 Retroactive correction of information regarding whether patient is a Member. Prior to rendering services, Transportation Vendor shall ask the patient to present his or her Member

identification card. In addition, Transportation Vendor may contact GLHP to obtain the most current information on the patient as a Member.

However, Transportation Vendor acknowledges that such information provided by GLHP is subject to change retroactively, under the following paragraph, (1) if GLHP has not yet received information that an individual is no longer a Member; (2) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (3) as a result of the Member's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information GLHP receives is later proven to be false.

If Transportation Vendor provides services to an individual, and it is determined within 12 months after the date of service that the individual was not a Member at the time the services were provided, those services shall not be eligible for payment under this Agreement and any claims payments made with regard to such services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Transportation Vendor, to the extent permitted by law, may then directly bill the individual, or other responsible party, for such services.

6.10 Payment under this Agreement is payment in full. Payment as provided under Section 6.6, together with any copayment, deductible or coinsurance for which the Member is responsible under the Benefit Plan, is payment in full for a Covered Service. Transportation Vendor will not seek to recover, and will not accept any payment from Member, GLHP or anyone acting in their behalf, in excess of payment in full as provided in this Section regardless of whether such amount is less than Transportation Vendor's billed charge or customary charge.

6.11 Member "Hold Harmless." Transportation Vendor will not bill or collect payment from the Member, or seek to impose a lien, for the difference between the amount paid under this Agreement and Transportation Vendor's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- i) Transportation Vendor's failure to comply with the Protocols,
- ii) Transportation Vendor's failure to file a timely claim,
- iii) GLHP's Payment Policies,
- iv) inaccurate or incorrect claim processing, or
- v) insolvency or other failure by GLHP to maintain its obligation to fund claims payments.

This obligation to refrain from billing Member applies even in those cases in which Transportation Vendor believes that GLHP has made an incorrect determination. In such cases, Transportation Vendor may pursue remedies under this Agreement against GLHP or Payor, as applicable, but must still hold the Member harmless.

Section 6.10 and Section 6.11 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.12 Consequences for failure to adhere to Member protection requirements. If Transportation Vendor collects payment from, brings a collection action against, or asserts a lien against a Member for Covered Services rendered (other than for the applicable copayment, deductible or coinsurance), contrary to Section 6.10 and 6.11 of this Agreement, Transportation Vendor shall be in material breach of this Agreement. This Section will apply regardless of whether Member or anyone purporting to act on Member's behalf has executed a waiver or other

document of any kind purporting to allow Transportation Vendor to collect such payment from Member.

In the event of such a breach, Payor may deduct, from any amounts otherwise due Transportation Vendor, the amount wrongfully collected from Members, and may also deduct an amount equal to any costs or expenses incurred by the Member, GLHP or Payor in defending the Member from such action and otherwise enforcing Section 6.10 through 6.12 of this Agreement. Any amounts deducted by Payor in accordance with this provision shall be used to reimburse the Member and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude GLHP from invoking any other remedy for breach that may be available under this Agreement.

6.13 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Transportation Vendor may not seek correction of a payment more than 12 months after it was made.

Transportation Vendor will repay overpayments within thirty days of notice of the overpayment. Transportation Vendor will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return such overpayment to GLHP within 30 days after posting it as a credit balance.

Transportation Vendor agrees that recovery of overpayments may be accomplished by offsets against future payments.

6.14 Toll-Free Phone Number. Payor shall be the owner of any toll-free number that Covered Members use to arrange transportation with Transportation Vendor.

Article VII. **Dispute Resolution**

7.1 The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see <http://www.adr.org>). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

7.2 Any arbitration proceeding under this Agreement shall be conducted in Oakland County, Michigan. The arbitrators selected will be knowledgeable as to the health care industry and shall not be affiliated, presently or previously, with the Parties to this Agreement. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary,

indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.

7.3 If the Dispute pertains to a matter which is generally administered by certain GLHP policies and procedures, such as claims payment, a quality improvement plan, such policies and procedures must be fully exhausted by Transportation Vendor before the Transportation Vendor may invoke any right to arbitration under this Article. The parties agree that all claim determinations by GLHP shall be considered final and not subject to the provisions of this Article VII or other review, arbitration, appeal, or adjudication in a court of law or other proceeding if not appealed in accordance with the administrative processes and appeal timeframes established in the Provider Manual.

To the extent one party raises a dispute regarding the failure to pay contracted rates, such party shall have obligation to provide an electronic spreadsheet setting out at a minimum the following information:

Member name; Member identification number; Member Social Security Number; Member date of birth; physician name; physician license number; physician provider number; date of service; procedure code/CPT Code; and amount billed.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The arbitrator(s) shall provide a written award that sets out the basis for his/her /their decision. The cost of the arbitration and attorneys' fees shall be borne as incurred by each party. All testimony shall be stenographically transcribed and the costs of the transcription shall be shared between the parties. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

7.4 In the event that any portion of this Article or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Article or Agreement. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration in accordance with this Article VII. While such arbitration remains pending, the termination for breach will not take effect.

This Article VII shall survive any termination of this Agreement.

Article VIII.

Term and Termination

8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of one year and renew automatically for renewal terms of one year, until terminated pursuant to Section 8.2.

8.2 Termination. This Agreement may be terminated under any of the following circumstances:

- i) by mutual written agreement of the parties;
- ii) by either party, upon 90 days written notice;
- iii) by either party upon 60 days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;
- iv) by either party upon 10 days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under Section 4.11 or Section 5.2 of this Agreement;
- v) by GLHP upon 10 days written notice in the event GLHP is required by a governmental authority to terminate this Agreement; or
- vi) by GLHP upon 10 days written notice in the event Transportation Vendor is acquired.

8.3 Ongoing Services to Certain Members After Termination Takes Effect. In the event a Member is receiving any Covered Services, as of the date the termination takes effect, Transportation Vendor will continue to render those Covered Services to that Member and this Agreement will continue to apply to those Covered Services, after the termination takes effect, until:

- i) his or her course of treatment is completed.
- ii) until he or she is discharged from an inpatient facility, if Member is confined in an inpatient facility on the date of the termination, or
- iii) the individual is no longer a Member, or
- iv) the Member's care is transferred to another provider which GLHP will use best efforts to do on a timely basis,

whichever is sooner.

GLHP will pay claims for any ongoing Covered Services that are rendered to Member in accordance with this Agreement in the amount set forth in the applicable services and payment appendix to this Agreement and in accordance with the Payment Policies.

8.4 Effect of Termination. In the event of termination of this Agreement, regardless of the reason for termination, the financial responsibility of Transportation Vendor for the provision of, or the reimbursement for, Transportation Vendor Services shall cease as of the date of termination; provided, however, that Transportation Vendor shall remain responsible for Transportation Vendor Services authorized by Transportation Vendor and received by the Covered Member prior to the date of termination. Following any termination, Transportation Vendor, at the request of the Payor, may continue to provide services under this Agreement for a period of not more than sixty (60) days in order to phase out the program, transition responsibilities to another provider, or to complete the current course of service to Covered Members. During such period, Payor shall compensate Transportation Vendor pursuant to the rates of reimbursement established in this Agreement.

Article IX.

Miscellaneous Provisions

9.1 Entire Agreement. This Agreement is the entire agreement between the parties with regard to the subject matter herein, and supersedes any prior written or unwritten agreements between the parties with regard to the same subject matter.

9.2 Amendment. This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by GLHP upon written notice to Transportation Vendor in order to comply with applicable regulatory requirements. GLHP will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 Change in Governing Law. If any applicable laws or regulations are enacted, amended, promulgated, repealed, or revised, whether or not retroactively, which affect any of the rights, duties, or obligations of the parties hereunder, this Agreement will be deemed amended to the extent required to remain in compliance with such laws and regulations, effective as of the date such laws or regulations become or became effective.

9.4 Indemnification by Transportation Vendor. Transportation Vendor agrees to indemnify and hold harmless the State, and Payor and its officers, directors, employees, and agents against all expenses, claims, losses, damages and liabilities (or actions in respect thereof), arising out of or resulting from the errors or omissions of Transportation Vendor, its officers, employees or agents occurring during or in connection with the performance by Transportation Vendor under this Agreement, but only if (a) the claim, or cause of action arises out of an error or omission by Transportation Vendor, (b) Payor has given reasonable notice to Transportation Vendor of the claim or cause of action, and (c) Payor has not, by act or failure to act, compromised the position of Transportation Vendor with respect to the resolution or defense of the claim, or cause of action.

9.5 Indemnification By Payor. Payor agrees to indemnify and hold harmless Transportation Vendor and its officers, directors, employees, and agents and any affiliate corporation and their officers, directors, employees and agents against all expenses, claims, losses, damages and liabilities (or actions in respect thereof), arising out of or resulting from the errors or omissions of Payor, its officers, employees or agents occurring during or in connection with the performance by Payor under this Agreement or arising out of or under the terms of a Coverage Agreement, but only if (a) the claim, or cause of action arises out of an error or omission by Payor or the claim arises out of a dispute over the scope of Covered Services due a Covered Member or eligibility under this Agreement or a Coverage Agreement, (b) Transportation Vendor has given reasonable

notice to Payor of the claim or cause of action, and (c) Transportation Vendor has not, by act or failure to act, compromised the position of Payor with respect to the resolution or defense of the claim, or cause of action.

9.6 Nonwaiver. The waiver by either party of any breach of any provision of this Agreement shall not operate as a waiver of any subsequent breach of the same or any other provision.

9.7 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by GLHP to any Affiliate.

9.8 Relationship of the Parties and Government Agencies. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties. Plan oversees, monitors, and remains accountable to federal, state, and city agencies with which it contracts for Government-Sponsored Programs, and nothing in this Agreement limits or terminates Plan's duties and obligations under these programs. Transportation Vendor's obligations and duties under this Agreement are and shall be construed consistent with the agreements for Government-Sponsored Programs between Plan and government agencies. Nothing contained in this Agreement shall impair the rights of any federal, state or city agency with jurisdiction over Plan. Nothing contained in this Agreement shall create any contractual obligation between Transportation Vendor and any federal, state or city agency.

9.9 No Third-Party Beneficiaries. GLHP and Transportation Vendor are the only entities with rights and remedies under the Agreement.

9.10 Delegation. GLHP may delegate (but not assign) certain of its administrative duties under this Agreement to one or more other entities. .

9.11 Notice. Any notice required to be given under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice. All written or electronic notices shall be deemed to have been given when delivered in person, by electronic mail, or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with proper addresses, facsimile numbers and electronic mail addresses of all designees that should receive certain notices or communication instead of that party.

As of the date of this Agreement, until such time as may be hereafter modified, all notices shall be sent to the following:

If to Transportation Vendor:

If the GLHP:

Network Contracting
Great Lakes Health Plan, Inc.
17117 W. Nine Mile Road, Suite 1600
Southfield, MI 48075

And to

Great Lakes Health Plan, Inc.
17117 W. Nine Mile Road, Suite 1600
Southfield, MI 48075

9.12 Confidentiality of Patient Information. The parties hereto mutually agree that, with respect to any and all patient records, files and other patient-related information (the "Patient Information") and any other data, reports, or information maintained pursuant to this Agreement shall be deemed "Confidential" or "Proprietary" information (the "other Confidential Information"), such that the receiving party shall ensure the confidentiality of all such Patient Information and Other Confidential Information and in doing so will take the same measures to ensure confidentiality as it would take to protect its own confidential or proprietary information. The receiving party shall ensure that Patient Information and Other Confidential Information is not disclosed to any third party, except to such Vendors, employees, and agents as require Patient Information or Other Confidential Information in order to properly perform their duties. This Article and the restrictions contained herein shall not apply to any information which the receiving party can demonstrate by written record (a) was already available to the public at the time of disclosure, or subsequently became available to the public, otherwise than by breach of this Agreement; (b) was in the possession of the receiving party prior to the date of this Agreement, but not already published; or (c) was the subject of a court order to disclose. For purposes of this Article, the compensation terms of this Agreement are "Confidential" notwithstanding disclosure prior to execution of this Agreement. The parties shall comply with the Health Insurance Portability and Accountability Act (HIPAA) with respect to the use and disclosure of medical information of Health Plan enrollees. All such information shall be considered confidential as required by law. If any provisions of this Agreement conflict with the requirements of HIPAA, HIPAA shall control.

Nothing in this Article shall preclude either party from disclosing information required to be disclosed pursuant to rule or regulation governing the business of either party; provided, however, that information referred to in this Article shall be disclosed only in the manner and to the extent required by such rule, regulation or statute.

9.13 Confidentiality of Proprietary Information. Neither party will disclose to a Member, other health care providers, or other third parties any of the following information (except as required by an agency of the government and then, as permitted by law, only after providing prompt notice of the governmental request to the party whose information is to be disclosed):

- i) any proprietary business information, not available to the general public, obtained by the party from the other party; or

- ii) the specific reimbursement amounts provided for under this Agreement, except to the extent necessary for claims processing.

Neither Payor nor Transportation Vendor shall use the other's name, symbols, trademarks, or service marks in advertising or promotional materials without the other party's prior written consent. Transportation Vendor specifically agrees to obtain Plan's written consent prior to distributing to Members any materials mentioning Plan. Notwithstanding the foregoing, Plan shall have the right to use the name of Transportation Vendor for purposes of marketing, informing Members of the identity of Transportation Vendor, and otherwise to carry out the terms of this Agreement.

9.14 Sole Responsibility. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any joint venture, partnership, or any other relationship among or between Transportation Vendor and Payor other than that of independent entities contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees or agents, shall be construed to be the agent, employees or representative of the other. Subject to any quality assurance protocols, or credentialing standards of this Agreement, the Transportation Vendor Vendors shall be solely responsible for transportation rendered to Covered Members.

9.15 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Michigan.

9.16 State Regulatory Addenda. One or more regulatory addenda may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under state law. These regulatory addenda, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between regulatory addenda and any other part of this Agreement, including but not limited to addenda, amendments and exhibits, the regulatory addenda will control.

9.17 Federal and State Funds. Payments to Transportation Vendor for Government-Sponsored Programs or other federal or state health care programs are derived, in whole or in part, from federal and/or state funds. Transportation Vendor shall be subject to all laws applicable to individuals and entities receiving federal funds, and may be civilly or criminally liable in the event of non-performance, misrepresentation, fraud, or abuse for services provided to Members.

By signing this Agreement, Transportation Vendor hereby (i) represents that it has not been debarred, excluded, suspended or otherwise determined to be ineligible to participate in federal or state health care programs (collectively, "Debarment" or Debarred," as applicable); and (ii) represents and warrants that it shall not knowingly employ or contract with, with or without compensation, any individual or entity (singularly or collectively, "Agent") listed by a federal agency as Debarred or which otherwise has been excluded or suspended from participation in federal or state sponsored health care program.

GLHP shall have the right to automatically terminate this Agreement in the event that Transportation Vendor is Debarred. Accordingly, Transportation Vendor shall provide GLHP immediate notice if it becomes Debarred.

9.18 Non-Waiver; Breach. No covenant, condition, duty, obligation or undertaking contained in or made a part of this Agreement shall be waived except by the express written agreement of

the parties, and forbearance and indulgence by either party shall not constitute a waiver of any covenant, condition, duty, obligation or undertaking to be kept, performed or discharged by the other party; and until complete performance or satisfaction of all covenants, conditions, duties, obligations, or undertakings by the breaching party, the other party shall have the right to invoke any remedy under this Agreement or under law notwithstanding any such forbearance or indulgence.

9.19 Severability. Any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction shall not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.20 Survival. Sections 4.17, 4.22, 5.7, 6.10, 6.11, Article VII and Sections 8.3, 9.12 and 9.13 shall survive the termination of this Agreement.

9.21 Captions and Headings. Captions, section headings, numbers and other like identifiers have been inserted for convenience of reference only, and if there is any conflict between such identifiers and the text of this Agreement, the text shall control.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT
MAY BE ENFORCED BY THE PARTIES.**

*Address to be used for giving notice
to _____ under the Agreement:*

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

Date _____ E-mail _____

Great Lakes Health Plan, Inc.

*Address to be used for giving notice
to Great Lakes Health Plan, Inc.:*

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

Date _____ E-mail _____

The following exhibits, appendices, addenda and attachments are incorporated by reference into this Agreement and made a part hereof:

- ___ Appendix 1. Transportation Product Application and Service Area
- ___ Appendix 2. Reimbursement and Covered Services
- ___ Appendix 3. Great Lakes Health Plan Transportation Protocols, Standards and Summary of Benefits
- ___ Appendix 4. Business Associate Agreement
- ___ Appendix 5. Transportation Vendor Guidelines
- ___ Appendix 6. State of Michigan Transportation Protocols

Appendix 1

Transportation Vendor Product Application and Service Area

This Agreement applies to Great Lakes Health Plan, Inc.'s Medicaid Product only by virtue of the plan's contract with the State of Michigan for the delivery of comprehensive health care services to Medicaid recipients.

The Great Lakes Health Plan service area under, which can be amended subject to the mutual consent of the parties, this Agreement applies to Medicaid enrollees who reside in the following Michigan counties:

- Hillsdale
- Huron
- Jackson
- Lenawee
- Livingston
- Macomb
- Oakland
- Saginaw
- Sanilac
- St. Clair
- Tuscola
- Wayne

Appendix 2

Reimbursement and Covered Services

Effective Date: July 1, 2006

Great Lakes Health Plan, Inc.

NON-EMERGENT TRANSPORTATION RATE SCHEDULE

Capitation Rate and Additional Reimbursement to Transportation Vendor

1. **Capitation Rate.** Payor shall pay Transportation Vendor a capitation rate of \$ _____ per member per month ("Capitation Rate"). This rate shall remain in effect without any adjustment for a period of two years from the effective date of this Agreement. The Capitation Rate shall be paid to Transportation Vendor on or about the 15th of every month for that month's current Member eligibility file.
2. **Additional Reimbursement.** In addition to the Capitation Rate, Payor agrees to reimburse Transportation Vendor for coordinating non-emergent transportation requests and services for GLHP Members who reside in the following counties: Barry, Van Buren, Kalamazoo, Calhoun, Berrien, Cass, St. Joseph, Branch, Allegan (otherwise defined as "Region 3"). GLHP's obligation to pay additional reimbursement to Transportation Vendor shall not occur until after the completion of the first four months of the Agreement which shall be calculated from the Agreement's effective date. After the expiration of the four-month period, Payor shall have the option of either paying a Capitation Rate of \$ ____ PMPM for coordinating requests for services by Region 3 Members or reimbursing Transportation Vendor \$ ____ for every call that it receives from a Region 3 Member. Regardless of the form of reimbursement, the parties agree that the level of reimbursement for Region 3 Members shall remain in effect for two years after the expiration of the four-month period unless Region 3 Members are incorporated into the Agreement's Capitation Rate, then the Capitation Rate shall apply.

Services Included in the Capitation Rate

- Coordinate the use and operation of GLHP's 1-800-number for non emergent call intake services as used exclusively by GLHP members
- Benefit and plan design consultation
- Plan set up (eligibility via tape or FTP)
- Transportation Vendor standard monthly report package
- Coordinate non-emergent Transportation requests and services for Region 3 GLHP Members for the first four months from the effective date of this Agreement and if Payor agrees to a one-time only Capitation Rate increase
- Adjudication of claims

- Toll-free call center open 7 days a week, 24 hours per day
- Vendor billing cycles every 4 weeks
- Mailing of vendor checks and remittance advice via first class US mail
- Selection of most appropriate, cost-effective vendors available.
- Development of plan to identify most cost-effective use of stretcher van and non-emergency ambulance transportation vendors with the ultimate objective of coordinating such use for the benefit of plan Members.
- Eligibility Verification
- Benefit Verification
- Provider Verification
- Scheduling of one-way and round-trip transportation
- On-site vehicle inspections
- Vendor credentialing and re-credentialing
- Fraud/Abuse Prevention and Detection Services
- Quarterly In-Service Meetings with Payor
- Gas Reimbursement Program
- Conducting Random Surveys

Appendix 3

**GREAT LAKES HEALTH PLAN TRANSPORTATION PROTOCOLS AND
SUMMARY OF BENEFITS**

CATEGORY	SERVICE ITEM	CLIENT SPECIFICATIONS
A. Customer Service Center Requirements		
A.1.	Standard Days and Hours of Customer Service Center Operation	<ul style="list-style-type: none"> ▪ Mon through Fri ▪ 8:00 am to 5:00 pm (EST)
A.2.	Holiday and Weekend Hours of Operation	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sat, 8:00 am to 5:00 pm (EST) <input type="checkbox"/> Sun, X:00 am to Y:00 pm (E,C,M, P) <input type="checkbox"/> Closed on Holidays <input type="checkbox"/> Open on Holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day)
A.3.	Greeting	Good morning/afternoon, Great Lakes Medical Transportation, this is XXX how may I help you?
B. SERVICE AREA		
B.1.	Service Area by County	<p>Hillsdale, Huron, Jackson, Lenawee, Livingston, Macomb, Oakland, Saginaw, Sanilac, St. Clair, Tuscola, Wayne</p> <p>Vendor to coordinate calls for members who reside in the following counties: Barry, Calhoun, Branch, St Joseph Kalamazoo, Van Buren, Cass, Berrien, Allegan. Coordination for this protocol means identifying the member's request and then transferring the call to another call center based in Kalamazoo for arrangement of the transportation service.</p>
B.2.	Transport outside of service	<ul style="list-style-type: none"> ▪ Requires plan approval

	area (define)	<ul style="list-style-type: none"> ▪ Call 800-903-5253 for authorization ▪ This would not apply to a Lenawee county member seeking services in Toledo
B.3	Is authorization required for long distance trips?	<ul style="list-style-type: none"> ▪ Yes, trips to a PCP that exceed 50 miles one way require plan approval ▪ Yes, trips to a specialist or medical facility that exceed 50 miles one way require plan approval ▪ Call 800-903-5253 for authorization
B.4	How should we handle requests for transportation out of state?	<ul style="list-style-type: none"> ▪ Not covered/covered ▪ Call 800-903-5253 for prior authorization
C. SCREENING CRITERIA		
C.1.	Who can request transportation?	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Member's parent or Legal Guardian calling to request transportation services on Member's behalf <input checked="" type="checkbox"/> Plan Case Manager or Care Coordinators only
C.2.	Days of Notice for Routine Medical Appointment	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
C.3.	Instructions if Member calls less than required days of notice	<ul style="list-style-type: none"> ▪ Educate Member, schedule trip and note in file ▪ If second attempt, educate Member, note in file and ask Member to reschedule appt to be within days of notice parameters. ▪ Notification of high risk members will be given to Case Management Department ▪ A monthly report will be generated for plan review
C.4.	Must Transportation Vendor Verify Appointments for same day and urgent trip requests?	x Yes <input type="checkbox"/> No
C.5	Is Door Side Service	Yes, but only on a case-by-case

	Available?	basis and plan must notify vendor in advance
C.6	Days of notice for High Risk Members	Encourage transportation vendor to respond to such cases within 24 hours of the request. Plan to provide a designate list of members who are classified as High Risk
C.7.	Must Transportation Vendor Verify Member Eligibility?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
C.8.	Instructions if Member is not listed on eligibility.	<ul style="list-style-type: none"> ▪ Call plan's Customer Service Center at 1-800-903-5253 ▪ Call plan's 24 hour eligibility line at 1-800-903-5253, select #3, then #1 ▪ Verify eligibility through provider portal
C.10.	Must Transportation Vendor verify Provider Participation status?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, and provider is not participating, then deny transportation request and note in file
C.11.	Must Transportation Vendor verify Closest Provider?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, and provider is not closest, then _
C.12.	Modes of Transportation Covered (check all that apply)	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sedan, taxi <input checked="" type="checkbox"/> Wheelchair equipped vehicle <input checked="" type="checkbox"/> Public transit <input checked="" type="checkbox"/> Mileage Reimbursement (\$0.40 per mile) <input checked="" type="checkbox"/> Shared Rides <input type="checkbox"/> Ambulance; requires prior authorization from plan <input type="checkbox"/> Stretcher Van; requires prior authorization from plan ▪ Call 800-903-5253 for authorization
C.13.	Criteria for use of public transit	<ul style="list-style-type: none"> ▪ Pick up and drop off sites are ¾ of a mile from bus line ▪ Follow Transportation Vendor criteria for use of public transit ▪ Inclement weather is a valid reason to cancel use of public transit and should be verified by reports of "snowy day" from the Michigan State Police or the US National

		<p>Weather Service</p> <ul style="list-style-type: none"> ▪ Vendor must have the ability to tag members that cannot use public transportation as defined by the plan
C.14.	Transport of a minor	<ul style="list-style-type: none"> ▪ Members traveling alone must be 16 years of age or older ▪ Members under age 16 must be accompanied by an adult at least 21 years or older ▪ If the Member is a single caregiver with more than one minor child in his/her care the Health Plan authorizes Transportation Vendor to transport the additional minor children
C.15.	Transportation to/from ER	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Not allowed to ER without prior auth from Great Lakes Health Plan <input checked="" type="checkbox"/> Allowed from ER to home <input checked="" type="checkbox"/> Not allowed between ERs <input type="checkbox"/> Allowed to and from ER
C.16.	Trips to the pharmacy	<ul style="list-style-type: none"> <input type="checkbox"/> Not allowed <input type="checkbox"/> Allowed <input checked="" type="checkbox"/> Allowed immediately following a doctor's appointment
C.17.	Additional Passengers	<ul style="list-style-type: none"> ▪ Member and one additional passenger allowed ▪ If Member is a single caregiver with more than one minor child in his/her care; the Health Plan authorizes Transportation Vendor to transport the additional minor children
C.18	Car Seat Use	Providers to comply with Michigan State law for car seat use
C.19	Prior Authorization Contact	<ul style="list-style-type: none"> ▪ Call plan Customer Service Department at 1-800-903-5253
C.20	Trip Limits	x No limit
C.21	Member Dispute or	<ul style="list-style-type: none"> ▪ Direct member to call

	Disagreement	Customer Service Department at 1-800-903-5253
D. COMPLAINTS MANAGEMENT		
D.1	When is the complaint/grievance report due?	<ul style="list-style-type: none"> ▪ Monthly, by the 10th day of the month for the previous month
D.2	Are there any reporting and/or resolution requirements that the state requires?	Complaints or Appeals must be resolved within 30 days of notice to Transportation Vendor.
D.3	What is the grievance/complaint intake process?	<ul style="list-style-type: none"> ▪ Complaints received by Transportation Vendor will be documented, investigated and resolved within five business days of receipt. Report to be delivered per section D.1 ▪ Complaints received by plan will be documented and immediately forwarded to Transportation Vendor for documentation, investigation and resolution. Report to be delivered per section D.1
D.4	Who should receive the report?	Plan Vice President of Service Operations

Appendix 3 Continued

Additional Protocols and Service Standards

Transportation Vendor shall comply with these additional protocols of GLHP, including but not limited to the following:

1. Medical Transportation Protocols as established by the Michigan Department of Community Health and attached to this Appendix 3, which include the following:
 - a. Assessment of a Covered Member's need and provide a Covered transportation service only if no other means are available to obtain Covered Services pursuant to the Assessment guidelines established in the attached State of Michigan Transportation Guidelines as set forth in Appendix 7.
2. Supplies and Equipment
 - a. Any and all supplies, equipment, uniforms and/or materials whatsoever, which may be necessary for the performance of this Agreement, shall be furnished by Transportation Vendor, at no additional costs to GLHP. All such materials and supplies shall be of high quality only.
3. Personnel
 - a. Transportation Vendor shall supply an adequate number of people who have been trained and are competent to perform the Services. Training will include vehicle orientation, first aid/CPR, customer service training, emergency evacuation, defensive driver, back protection and wheelchair securement and restraint. All persons employed in connection with the Services are and shall be deemed employees of Transportation Vendor and not of GLHP. Such employees shall at all time be under Transportation Vendor's direction and control. Transportation Vendor assumes all responsibility for timely compliance with all local, state and federal labor and tax laws including, but not limited to, Fair Labor Standards Acts, Occupational Safety and Health Act, federal and state withholding tax law's, worker's compensation insurance, FICA and federal and state unemployment insurance laws, and, if any violations of such laws or regulations occur, the cost, fines and penalties resulting, if any, shall be paid by Transportation Vendor, without reimbursement by GLHP. With respect to Transportation Vendors's subcontractors, Transportation assumes all responsibility for compliance with applicable law, including issuance of IRS 1099 forms.

4. Monthly and Quarterly Reporting. *The following expectations and measurements will be maintained and reported to GLHP by Transportation Vendor on a monthly and quarterly basis. In the event that the minimum standards below are not met on a quarterly basis, then a corrective action shall be implemented to establish compliance in subsequent months. If the corrective action plan cannot be satisfied within three months of implementation, then GLHP shall have the discretion to impose a penalty of an amount not to exceed 5 percent of the Transportation Vendor's current Capitation Rate unless such non-compliance is due to conditions outside of Transportation Vendor's control.*

The following criteria are measured, responded to and reported both internally and to the health plan:

Criteria	Standard
1. Timely Performance	Transports with 24 hours notice: Arrive within 15 minutes of the scheduled pick-up time at least 95% of time. Transports with less than 24 hours notice: Arrive with 30 minutes of the scheduled pick-up time at least 75% of the time.
2. Vehicle Operating Standards	Vehicles must meet safety and cleanliness standards 100% of the time.
3. Provider No-Shows	Less than 1% of all transports assigned and accepted by the provider.
4. Multi-Load Times	In multi-load situations, passengers not to remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transport 100% of the time.
5. General Load Time	100% compliance with ADA requirements when applicable. On-board times no greater than 60 minutes 100% of the time for all other passengers.
5. Driver Standards	100% compliance
6. Complaints to Transports Ratio	Less than 1%
7. Rings to Answer	Within 3 rings 95% of all calls
8. Call Abandonment	Less than 5% of all calls
9. Recipient Satisfaction	97%
10. Complaints to	Less than 1%

Calls Ratio	
11. Proper Vendor Assignment	More than 98.5%
12. Timely Reporting	100%

5. Telephone System Requirements. Transportation Vendor will be required to provide intake translation or recorded messages for GLHP members including, but not limited to, the following languages:

- English
- Spanish
- Russian
- Laotian
- Hmong
- Arabic

Transportation Vendor will be required to provide a recorded emergency message to direct members to call 911 after hours for emergencies, or for non-emergent calls direct members to the GLHP customer service line at 1-800-903-5253.

6. Member Satisfaction Surveys. Transportation Vendor will be expected to distribute member satisfaction surveys (created by GLHP), upon the pickup of a GLHP member. Surveys will be self-address stamped cards that members can drop into a postal box upon completion of ride.

7. Transportation Vendor Site Access. Transportation Vendor will provide access, on request, to GLHP personnel for the purpose of call center monitoring, conducting ride-alongs and vehicle aesthetic inspection.

Appendix 3 Continued

Great Lakes Health Plan Summary of Benefits

Service	Code	Covered	Excluded	Special Instructions
Abortion	50		X	
Adult Day Care	80		X	
Alcohol Abuse Evaluation to Enter Treatment	01		X	
Alcoholics Anonymous Meetings	81		X	
Alcohol Rehabilitation	82		X	
Allergy (doctor visits, testing and injections)	02	X		
Alternative Health Care (e.g. acupuncture)	79		X	
Cardiac Rehab	35	X		
Chemotherapy	34	X		
Chiropractor	83	X		
Cosmetic Surgery	86		X	
Counselor (specify any limits)	29	X		Limited to 20 visits per year
Court Ordered Exams or appointments	52		X	
Dental Exams	44		X	
Dental Services (other than exams)	03		X	Only covered in hospital
Diabetic Supplies and Education	33	X		
Dialysis	04	X		
Drug Abuse Evaluation to Enter Treatment	05		X	
Drug Rehabilitation	53		X	
Durable Medical Equipment	06	X		
Experimental Medical Procedures/Drugs	87		X	
Family Planning Clinic Services	07	X		
Federally Qualified Health Centers (FQHC)	65	X		
Foot Care (Routine)	24	X		
Group Therapy (specify any limits)	54	X		Part of psych and limited visits per year
Hearing Aids (testing, fitting, repairs)	08	X		
Hospital - Admission	09	X		
Hospital - Discharge	10	X		
Hospital - Outpatient services	12	X		
Hospital to Hospital	11	X		
Hospital Visitation (i.e. mom to see newborn)	36			
Immunizations	13	X		
Infertility Services	55		X	
Laboratory Services	14	X		
Lamaze Classes (or similar birthing class)	56			
Lead Screening/Testing	37			
Mammogram	38	X		

Nursing Home to Nursing Home	39	X		
OB/GYN services	40	X		
Occupational Therapy (specify any limits)	15	X		
Optical - Contact Lenses	16		X	
Optical - Exams	67	X		
Optical - Eyeglasses	17	X		
Orthodontics	57		X	
Orthotic Services	18	X		
Pain Management	20	X		
Pediatric Services	48	X		
Pharmacy	21	X		
Service	Code	Covered	Excluded	Special Instructions
Physical Therapy (specify any limits)	46	X		
Physician Services	22	X		
Podiatry	23	X		
Prosthetic services	24	X		
Psychiatric Facility	27		X	
Psychiatric Services	92	X		Limited to 20 visits per y
Psychiatrist (specify any limits)	28	X		Limited to 20 visits per y
Psychologist (specify any limits)	58	X		Limited to 20 visits per y
Radiation Treatments	91	X		
Radiology Services (X-rays, MRI)	41	X		
Rehabilitation Services (specify any limits)	42	X		
Rural Health Clinic Services (RHC)	59	X		
Self Help Group Meetings	30		X	
Smoking Cessation	93	X		
Social Security Office (SSI)	62		X	
Social Worker (specify any limits)	31	X		Limited to 20 visits per y
Speech Therapy (specify any limits)	94	X		
SSI Determination Medical Appointment	96		X	
Support Groups	63		X	
Transplant Services	43	X		
Transportation from Urgent Care Facility	61	X		
Transportation to Urgent Care Facility	60	X		
Vision/Hearing Screenings	47	X		
Vocational Rehabilitation	98		X	
Weight Control Programs	66		X	
WIC Appointments – After Pregnancy	64	X		
WIC Appointments – During Pregnancy	99	X		
Other				
Other				
Other				

Appendix 4

Business Associate Agreement

This Business Associate Agreement is made on _____ [insert date] by and between _____ [insert Business Associate's name] and _____ [insert name of AmeriChoice plan/business entity], a UnitedHealth Group company and its successors or assigns. This agreement provides the terms and conditions governing the exchange between the parties of Protected Health Information (PHI) and/or Nonpublic Personal Information ("Personal Information"), as both terms are defined below, during the performance of its obligations under this Agreement. This agreement will remain in effect until terminated according to its terms.

I. Definitions

- 1.1 Unless otherwise specified in this Agreement, all terms used, but not otherwise defined, in this agreement have the same meaning as those terms in Title 45 parts 160 and 164 of the Code of Federal Regulations (C.F.R.), as amended from time to time.
- 1.2 "Protected Health Information" or "PHI" has the same meaning as in 45 C.F.R. § 160.103. It is broadly defined as individually identifiable information, including demographic information, related to past, present or future mental or physical health or condition, the provision of health care to an individual, or the past, present or future payment for such health care.
- 1.3 Nonpublic Personal Information or "Personal Information" has the meaning as defined by the Gramm-Leach-Bliley Act (GLB) and implementing regulations.

II. Obligations and Activities of Business Associate

- 2.1 Business Associate understands and acknowledges that it may receive from or create or receive on behalf of Covered Entity PHI and/or Personal Information during the performance of its obligations under this agreement.
- 2.2 Except as otherwise specified herein, Business Associate may use or disclose PHI and Personal Information received from or created or received on behalf of Covered Entity to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Agreement, provided that such use or disclosure would not violate the HIPAA privacy regulations, GLB or other federal or state privacy laws applicable to Covered Entity, if done by Covered Entity.
- 2.3 With regard to its use and/or disclosure of PHI or Personal Information, Business Associate hereby agrees and represents and warrants to Covered Entity that Business Associate shall:
 - (a) not use or further disclose any PHI or Personal Information other than as permitted by this Agreement or required by law,
 - (b) at all times maintain and use appropriate safeguards to prevent uses or disclosures of any PHI or Personal Information other than as permitted by this Agreement or required by law;
 - (c) ensure that any subcontractor or agent to whom it provides any PHI or Personal Information agrees in writing to the same conditions and restrictions that apply to Business Associate with regard to the PHI or Personal Information, including, without limitation, all of the requirements of this Agreement.
- 2.4 With regard to its use and/or disclosure of PHI, Business Associate hereby agrees and represents and warrants to Covered Entity that Business Associate shall:
 - report promptly to Covered Entity any use or disclosure of any PHI of which it becomes aware that is not permitted by this Agreement;
 - mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement; in the time and manner designated by Covered Entity, make available PHI in a Designated Record Set, to Covered Entity, or as directed by Covered Entity, to an individual, in order for Covered

Entity to respond to individuals' requests for access to information about them in accordance with the HIPAA privacy regulation;
in the time and manner designated by Covered Entity, make any amendments or corrections to the PHI in a Designated Record Set that Covered Entity directs in accordance with the HIPAA privacy regulation;
in the time and manner designated by Covered Entity, document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with the HIPAA privacy regulations;
in the time and manner designated by Covered Entity, make available to Covered Entity, or as directed by Covered Entity, to an individual, the information documented in accordance with subsection (d) above, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures, in accordance with the HIPAA privacy regulations;
in the time and manner designated by Covered Entity or the Secretary of HHS, make its internal practices, books and records relating to the use and disclosure of PHI available to Covered Entity or to the Secretary of HHS for purposes of determining Covered Entity's compliance with the HIPAA privacy regulations.

2.5 With regard to the security of PHI, Business Associate hereby agrees, represents and warrants to Covered Entity that Business Associate shall:

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity as required by 45 CFR Part 164.314(a)(2)(i);
Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and
Report to the covered entity any security incident of which it becomes aware.

III. Term and Termination

3.1 The term of this Agreement shall be effective as of _____ [Insert effective date] and shall terminate when all PHI provided by Covered Entity to Business Associate or created or received on behalf of Covered Entity is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the PHI, protections are extended to such information in accordance with the termination provisions of this agreement. Each term and condition of this Agreement required by HIPAA and/or GLB shall be effective on the compliance date applicable to Covered Entity, or this Agreement, under the HIPAA privacy regulation and/or GLB, respectively.

3.2 Business Associate agrees that this Agreement may be terminated by Covered Entity upon written notice to Business Associate in the event that Covered Entity determines that Business Associate has violated any material term of this Agreement. Alternatively, Covered Entity may choose to provide Business Associate with written notice of the existence of an alleged material breach of this Agreement and afford Business Associate an opportunity to cure said breach upon mutually agreeable terms. Failure to cure, or a determination by Covered Entity that cure is not practicable or possible, shall be grounds for the immediate termination of this Agreement. Business Associate agrees to defend, indemnify and hold harmless Covered Entity against any and all claims, liabilities, judgments or damages asserted against, imposed upon or incurred by Covered Entity that arise out of any violation of this Agreement.

3.3 (a) Except as provided for in subsection (b) below, upon the termination of this Agreement for any reason, Business Associate shall return to Covered Entity or destroy all PHI and/or Personal Information,

and retain no copies in any form whatsoever. This provision shall apply to PHI and/or Personal Information that is in the possession of subcontractors, vendors or agents of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the PHI and/or Personal Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If Covered Entity agrees that return or destruction of PHI and/or Personal Information is infeasible and further agrees that Business Associate shall maintain such PHI and/or Personal Information, Business Associate shall extend the protections, limitations and restrictions of this Agreement to such PHI and/or Personal Information and limit further uses and/or disclosures of such PHI and/or Personal Information to those purposes that make the return or destruction of the PHI and/or Personal Information infeasible, for so long as Business Associate maintains such PHI and/or Personal Information; provided that such uses and/or disclosures of PHI and/or Personal Information shall never exceed those uses and/or disclosures permitted or required under this Agreement.

(c.) If Covered Entity does not agree that return or destruction of PHI and/or Personal Information is infeasible or, if for any other reason, Covered Entity does not agree to that Business Associate shall maintain such PHI and/or Personal Information, Business Associate shall return or destroy such PHI and/or Personal Information in accordance with subsection (a) above.

IV. Amendment and Interpretation

4.1 The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the HIPAA privacy regulations, GLB and other federal and state privacy and consumer rights laws and regulations applicable to Covered Entity. Business Associate agrees to cooperate with and assist Covered Entity in order for Covered Entity to meet its obligations under applicable privacy laws and regulations.

The terms and conditions of this Agreement required by HIPAA shall be construed in light of any applicable interpretation of and/or guidance on the HIPAA privacy regulation issued by HHS from time to time. Any ambiguity in this section shall be resolved in favor of a meaning that permits Covered Entity to comply with applicable laws and regulations

4.2 This Agreement creates no third party beneficiaries; the Covered Entity and Business Associate are the only entities with rights and remedies under this Agreement.

4.3 Neither party may assign this Agreement without the other party's prior written approval; such approval not to be unreasonably withheld. Covered Entity may, however, assign this Agreement to an entity that is related by ownership or common control.

In Witness Whereof, the parties have executed this Agreement as of the date first above written:

Covered Entity:

Signature _____

Printed Name _____

Title _____

Business Associate:

Signature _____

Printed Name _____

Title _____

Appendix 5

Transportation Vendor Guidelines

[SEE ATTACHED]

Appendix 6

State of Michigan Transportation Protocols

[SEE ATTACHED]