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

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

September 28, 2005

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075** **Csherer@glhp.com**	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 **N/A**	SHIPMENT **with three 1 year renewal options** **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE (S):

Please note the following change:

Effective 6/1/05 the attached subcontract agreement with Dental Benefits Providers, Inc. is hereby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and vendor contact (Rose Myers) dated 6/1/05.

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

June 1, 2005

Ms. Irene Pena, CPPB
DMB Acquisition Services
Mason Building, 2nd Floor
530 West Allegan
Lansing, MI 48933

Dear Ms. Pena:

In accordance with the contract with the State of Michigan and Great Lakes Health Plan ("GLHP"), I am submitting for your review, a contract for a sub-contractor that was not part of the original Invitation to Bid.

GLHP wishes to contract the services of Dental Benefits Providers, Inc. ("DBP") to provide dental benefits to GLHP Medicaid members age 21 and over.

All required information is attached including, but not limited to:

- Subcontractor Name
- Associated Fees
- Description of Services to be Performed

As you will notice, the effective date of the contract is July 1, 2005 which is within the 21 day required notice to you.

Please contact me if you have any questions or concerns at 248.331.4357 or rmyers@glhp.com.

Sincerely,

Rose Myers
Government Programs Liaison

cc: Darryl Bragg, Department of Community Health

DENTAL BENEFIT PROVIDERS SERVICES AGREEMENT

THIS SERVICES AGREEMENT (this "Agreement"), effective on July 1, 2005 ("Effective Date"), is between Dental Benefit Providers, Inc. ("DBP"), a company that provides network management and administration services for dental health care, and Great Lakes Health Plan, Inc. ("GLHP").

Article 1
Definitions

Benefit Contract: A benefit plan established by a Payor group for its members and their dependents that contains the terms and conditions of a Member's coverage, regardless of funding mechanism.

Change in Control: A change in ownership of more than 50% of the outstanding voting securities or other equity interests of an entity.

Copayment: An amount identified in a Benefit Contract, if any, that may be due and payable by a Member directly to a Provider for a specific Dental Service. Copayments typically are described as a flat dollar amount for each particular type of service or supply.

Coinsurance: An amount identified in a Benefit Contract, if any, that is due and payable by a Member directly to Providers for specific Dental Services, independent of any required Copayments or Deductibles. Coinsurance amounts typically are described as a percentage of the Provider's charges or contracted fees for the applicable services or supplies.

Covered Services: The health care services and supplies covered by a Member's Benefit Contract including any Dental Services.

DBP Services: The services that DBP provides or arranges, as described in Article 2 and elsewhere in this Agreement, including Dental Services provided to Full Service Members.

Deductible: An amount for Dental Services and/or other health care services that a Member may pay before the Member is eligible for coverage under the Benefit Contract.

Dental Provider: A licensed or otherwise appropriately qualified and credentialed dental professional or entity that has a written participation agreement in effect with DBP, directly or through another entity, to provide Dental Services to Members.

Dental Services: The dental care services included in Members' Benefit Contracts that is offered by GLHP. The covered dental care services are described in the Dental Services Description and Certificate of Coverage Addenda.

Full Service Member: Members who are enrolled in Benefit Contracts for which DBP has agreed to be financially responsible for all or part of the cost of Dental Services.

Full Service Payment: An amount equal to the Full Service Rate multiplied by the number of Full Service Members who are enrolled in Benefit Contracts for the month for which the Full Service Rate applies.

Full Service Rate: The amount to be paid to DBP for each Full Service Member per month that is specified in the DBP and Dental Services Description and Fee Appendix attached to this Agreement or the Participating Organization DBP and Dental Services Description and Fee Appendices attached to the Participating Organization Addenda.

Member: Any individual who is eligible for, and properly enrolled and covered under a Benefit Contract or other arrangement of GLHP, is 21 and over, and resides in the Michigan counties of Wayne, Oakland or Macomb, only.

Member Expense: Any amounts that may be the Member's responsibility to pay a Provider for Dental Services in accordance with a Member's Benefit Contract, including Copayments, Coinsurance, and Deductibles.

Payor: GLHP has the financial responsibility for payment of Dental Services covered by a Benefit Contract, and shall, for the purposes of this Agreement, be the Payor. A Payor may include, without limitation, fully insured plans, self-funded plans and network leasing arrangements.

Service Area: The geographic area in which GLHP is authorized by a state to provide coverage for health care services, including Dental Services, to Members.

Article 2
DBP Services

Section 2.1 Description of DBP Services. DBP shall arrange for or provide to GLHP the services described in Sections 2.1.1 – 2.1.4 below. The DBP and Dental Services Description and Fee Appendix, respectively, will identify the specific DBP Services and functions to be provided to the Members.

Section 2.1.1 Dental Provider Network Development and Management.

(a) **Network Development.** DBP shall arrange for Dental Providers to provide Dental Services to Members. GLHP may recommend to DBP that certain providers become Dental Providers. In no case shall this provision be construed to obligate DBP to contract with or make use of any particular health care facility or professional. DBP retains full and complete rights to terminate a Dental Provider's agreement with DBP. DBP makes no representations or guarantees regarding the continued availability of any Dental Provider.

(b) **Dental Provider Credentialing.** DBP shall establish and maintain a credentialing and re-credentialing process to which all Dental Providers shall be subject. Upon GLHP's written request, DBP shall provide GLHP with a copy of DBP's credentialing process. DBP's credentialing process shall comply with the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency"). Additionally, DBP must provide the following reports to GLHP upon request: Denial rate reports; aged claims reports; claims audit reports; coordination of benefits collection from third parties reports; and any other reports that may be required by a state or federal government agency. With reasonable notice and during normal business hours, GLHP may conduct comprehensive onsite evaluation of DBP's credentialing procedures.

(c) **Geographic Access.** Upon GLHP's written request, DBP shall provide GLHP with a current listing of Dental Providers. In the event GLHP reasonably determines that there are not sufficient Dental Providers to provide Dental Services to Members:

- GLHP shall notify DBP of the alleged deficiency;
- GLHP and DBP shall meet to discuss the alleged deficiency, and
- If appropriate, develop a mutually satisfactory plan of correction within 30 days of such notice.

GLHP shall notify DBP in writing at least 90 days prior to any modification of GLHP's Service Area. DBP shall use best efforts to arrange for Dental Providers in such expanded Service Area within 90 days of receiving such notice, at which time the definition of Service Area in this Agreement shall include such expansion without further compliance with Section 11.2.

(d) **Dental Provider Agreements and Manuals.** Upon written request, DBP shall provide GLHP a copy of DBP's then current generic written participation agreement that DBP uses when contracting with Dental Providers and any related provider manuals. DBP's Dental Provider agreements will require Dental Providers to comply with the applicable obligations in this Agreement. DBP and GLHP shall work together in good faith to address any concerns GLHP has regarding the content of such agreements or manuals

DBP shall ensure that its agreements with Dental Providers and related manuals comply with applicable laws, regulations and Accrediting Agency standards. DBP shall cooperate with and provide to Participating Organizations copies of Dental Provider agreements and manuals that Participating Organizations are required to file or submit to regulators or for accreditation purposes.

In the event DBP intends to make any substantial changes to its Dental Provider agreements or manuals that would materially affect this Agreement or require filing or submission to GLHP's or a Dental Network Customer's regulators or Accrediting Agencies, DBP shall notify GLHP of such proposed changes before they are effective and DBP, and GLHP shall work together in good faith to resolve any concerns GLHP may have about the proposed changes and to complete any filing or submission the Participating Organizations are required to make.

(e) **GLHP Compliance with Dental Provider Agreements.** GLHP will use commercially reasonable efforts to comply with the applicable obligations set forth in the DBP's agreements with Dental Providers.

(f) **Discontinuing Use of a Dental Provider.** DBP shall discontinue making referrals to or otherwise using a Dental Provider to provide Dental Services to Members as follows:

(i) immediately upon DBPs receipt of written notice that the Dental Provider's license or certification has been revoked, suspended or otherwise limited,
(ii) immediately upon DBP's receipt of written notice that the Dental Provider's liability insurance has been revoked.
(iii) immediately upon DBP's receipt of written notice that the Dental Provider has been sanctioned by CMS.

(iv) on termination of the Dental Provider's agreement with DBP.

DPB will notify GLHP, in writing, of the names of any new Dental Provider within 15 days of the end of the calendar month in which the Dental Provider begins to provide services Members. DBP will notify GLHP, in writing, of the names of any Dental Providers whose contracts with DBP have been voluntarily or involuntarily within 15 days of the end of the calendar month in which the termination is effective.

Section 2.1.2 Quality Management. DBP shall establish and maintain its own quality management program and such other assessment and improvement programs it determines appropriate. DBP shall cooperate with, and shall use reasonable efforts to ensure Dental Providers cooperate with, any such reasonable and similar programs established or required by GLHP or a Payor.

Section 2.1.3 Medicaid and State Regulatory Addenda. DBP shall and shall require Dental Providers to comply with the applicable terms and conditions of GLHP's Michigan Medicaid Managed Care Contract with respect to any Michigan Medicaid Managed Care Benefit Contract and/or Medicaid Members. DBP shall and shall require Dental Providers to comply with the terms and conditions of any and all state regulatory addenda attached to this Agreement.

Section 2.1.4 Customer Service Activities. DBP shall provide a toll free customer service number to all Members. All Member questions related to DBP coverage shall be directed to DBP customer service representatives, and DBP shall be responsible for providing accurate and timely information to Members. DBP will operate a call center to service providers on any claims inquiries. The Call Center (whose hours shall be at a minimum, Monday through Thursday 8:30 AM to 8:00 PM and Friday 9:00 AM to 8:00 PM) will have the ability to triage calls based on the severity of the issue to be resolved allowing for immediate resolution when appropriate. Those calls requiring GLHP assistance will be routed to GLHP Customer Service for resolution. DBP agrees that call response time will adhere to state contract guidelines.

Section 2.2 General Services. In addition to the services described in Section 2.1, DBP shall provide the following :

(a) **Reporting.** DBP shall provide to GLHP reasonable and customary management reports similar in kind and nature to those provided other DBP clients. DBP shall also provide to GLHP any standard reports necessary to comply with DBP's and/or GLHP's Accrediting Agencies. DBP shall provide such reports to GLHP no later than thirty (30) working days after the end of each calendar quarter or as otherwise appropriate for the particular report.

(b) **Data Feed.** DBP shall make commercially reasonable efforts to provide an electronic data feed of Dental Provider contract information required to for basic service calls from Members serviced by GLHP's systems such as Facets. To the extent such method is achieved and is to be put into use, the parties agree to execute such amendments to this Agreement as are necessary to address legal requirements, including, but not limited to, those required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other concerns related to such transmission.

(c) **Surveying.** DBP shall cooperate with GLHP with surveys of a sample of Members who have accessed Dental Services pursuant to this Agreement and/or Dental Providers to

assess satisfaction with DBP. DBP shall work with GLHP to develop and administer surveys.

If areas of dissatisfaction are identified as a result of such surveys, DBP will develop commercially reasonable corrective strategies on mutually identified areas of concern.

Section 2.3 Non-Interference with Advice to Members. Nothing in this Agreement is intended to prohibit or restrict Dental Providers from advising or advocating on behalf of a Member about:

(a) the Member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Member to provide an opportunity to decide among all relevant treatment options;

(b) the risks, benefits and consequences of treatment or non-treatment; and

(c) the opportunity for the Member to refuse treatment and express preferences about future treatment decisions.

DBP shall require Dental Providers to provide information regarding treatment options in a culturally competent manner, including the option of no treatment. DBP shall require Dental Providers to assure that individuals with disabilities are furnished with effective communications in making decisions regarding treatment options.

Article 3
Eligibility for DBP Services

Section 3.1 Member Eligibility Information. At least monthly, on a date mutually acceptable to GLHP and DBP, GLHP shall provide DBP with a current list of the eligible Members in an electronic format mutually agreeable to both parties. The eligibility information shall be prepared and provided to DBP at GLHP's expense. DBP shall treat the information received under this paragraph as confidential and shall not distribute or furnish such information to any other person or entity, except as necessary, pursuant to DBP's standard practices and as allowed by law, to provide or arrange for the DBP Services.

In the event GLHP is unable to provide DBP with a current list of eligible members in an electronic format, the parties agree to adjust the compensation payable to DBP pursuant to this Agreement should such alternative process cause DBP to incur additional costs.

Section 3.2 Retroactive Adjustments of Eligibility. DBP acknowledges that there will be favorable and unfavorable retroactive adjustments to Member eligibility. GLHP shall use its best efforts to minimize such adjustments. Notwithstanding the above, the parties agree that DBP shall not be financially liable for any claims for Dental Services for Full Service Members related to such retroactive adjustments of greater than sixty (60) days.

Article 4
Identification, Modification, and Communication of Benefits and DBP Services

Section 4.1 Benefit Contracts. This Agreement is not intended nor shall it be deemed or construed to modify the obligations of GLHP to Members as established by GLHP under any Benefit Contracts.

Section 4.2 Services Under This Agreement. This Agreement is the agreement among GLHP and DBP regarding the rights, responsibilities and other conditions for the provision and payment of DBP Services. The responsibilities of DBP shall be limited as defined by the terms of this Agreement.

In the event a GLHP elects to offer coverage to Full Service Members for dental treatment or care that are not Dental Services as defined in this Agreement, for whatever reason, including a decision by GLHP to provide extra-contractual benefits, GLHP shall be responsible for the cost of providing or arranging for such dental treatment or care. If DBP provides or arranges for the requested dental treatment or care in such situation, GLHP shall pay DBP the amounts payable to Dental Providers or non-Dental Providers for such dental treatment or care.

Section 4.3 Benefit Contract Design. GLHP will use commercially reasonable efforts to draft and modify Benefit Contract designs as requested by DBP to maximize in-network utilization of Dental Providers.

Section 4.4 New Benefit Contracts and Changes to DBP Services. With respect to Benefit Contracts, GLHP shall use commercially reasonable efforts to notify DBP in writing at least 120 days before:

(a) filing any modification to an existing Benefit Contract which would result in a material modification to Dental Service coverage; or

(b) developing a new Benefit Contract that includes a material modification to the Dental Service coverage under existing Benefit Contracts.

In the event that GLHP modifies the terms of any Benefit Contract or develops a new Benefit Contract template, where such modification or new Benefit Contract template is deemed by DBP to be a material change to DBP's obligations under this Agreement or the pricing assumptions used in establishing rates, the management of, or arrangement for, DBP Services related to such modification, the parties shall negotiate to include the modification in this Agreement in accordance with Section 11.9.

Following successful negotiation in accordance with Section 11.9, GLHP, as the case may be, and DBP shall execute an amendment to the Dental Services Description and Rates Addendum or Participating Organization Addendum, respectively, to reflect the modification of the Benefit Contract.

Section 4.5 Communication Materials and Activities. GLHP shall periodically inform and instruct Members through various publications and programs jointly established by GLHP available to Members. GLHP must receive DBP's permission before using any of DBP's copyrighted materials in their communications materials.

If GLHP produces its own communications materials, it shall do so at its own cost and shall submit the materials that describe DBP Services to DBP for DBP's prior review and approval.

GLHP shall use its best efforts to include legally required notices regarding DBP Services or other legally required communications related to DBP in their scheduled mailings at no cost to DBP. In the event GLHP, despite their best efforts, are unable to include legally required communications in a packaged mailing, DBP will reimburse GLHP for actual mailing costs, not to include personnel and other internal expenses.

Article 5
Claims Administration, Benefit Administration and Coverage Disputes

Section 5.1 Claim Administration. DBP shall or shall arrange for a third party administrator ("TPA") to process claims for Dental Services. The TPA must have all required regulatory approvals to do business in any of the states in which claims may be submitted by Members, Dental Providers or other Providers. DBP shall arrange for Dental Providers to submit claims for Dental Services to DBP or the TPA. Claims shall be paid in accordance with the terms and conditions of the Benefit Contracts, DBP's agreements with Dental Providers, and this Agreement.

Section 5.2 Benefit Administration. DBP and/or TPA shall make initial determinations whether services and/or supplies requested by or on behalf of a Member or for which a Member has requested reimbursement are Dental Services.

With respect to Full Service Members, DBP has the final, binding, and exclusive discretionary authority with regard to the payment of any claim for which DBP has financial responsibility under this Agreement, except as otherwise provided by Section 5.4 of this Agreement. If DBP determines that the requested services and/or supplies are not Dental Services, DBP shall notify the Full Service Member about the lack of coverage and the Full Service Member's rights under the Benefit Contract to appeal a denial of coverage.

Section 5.3 Member Appeal and Grievance Process. In the event of disputes with a Member or Provider regarding coverage of Dental Services, DBP shall refer the Member or Provider to the appropriate appeal and grievance processes under the Member's Benefit Contract. DBP shall cooperate with GLHP with respect to any such appeal or grievance processes. In addition, the following shall apply:

(a) Full Service Members. The result of the Member appeal and grievance process shall be binding on DBP, unless DBP notifies GLHP that DBP disagrees with such result within 15 business days after DBP receives notice of the result. In such case, GLHP may authorize coverage and pay for the provision of the services and/or supplies in dispute, and the parties shall proceed with the dispute resolution process described in Section 5.4.

Section 5.4 Coverage Disputes between DBP and GLHP Regarding Full Service Members. In the event:

(a) of a dispute between DBP and GLHP whether particular services and/or supplies for a Full Service Member are Dental Services for which DBP has financial responsibility; or

(b) if GLHP enters into a settlement agreement with a Full Service Member as a result of actual or threatened grievance, arbitration or litigation,

and GLHP and DBP do not agree on financial liability for such services ("Coverage Dispute"), the parties shall comply with the following Coverage Dispute Resolution Procedure:

(a) The Coverage Dispute shall be submitted to GLHP's and DBP's Medical Directors, or equivalent, for review;

(b) The Medical Directors shall issue their determination within 7 business days after submission and receipt of appropriate and necessary information.

(c) In the event there continues to be a Coverage Dispute after the Medical Directors' review, the parties shall submit the Coverage Dispute to the most senior executive at each organization, who shall issue their determination within 7 business days after submission.

(d) In the event there continues to be a Coverage Dispute, the affected parties may initiate legal action.

Article 6
Compensation

Section 6.1 Payments to DBP. GLHP shall pay DBP the rates established in the DBP and Dental Services Description and Rates Appendix on or before the 15th day of each month based on the then current information available to GLHP limited to the number of Members who are ages 21 and over and who reside in the Michigan counties of Wayne, Oakland or Macomb only, for that month. A person shall be considered a Member for purposes of payment under this Section if he or she was a Member on the 15th day of the month, is age 21 and over, and resides in the counties of Wayne, Oakland or Macomb, only. The monthly payment will be reconciled for retroactive adjustments of eligibility from previous months in accordance with Section 3.2.

Section 6.2 Transfers of Funds. GLHP shall be responsible for depositing or transferring the Full Service Payments on or before the 20th day of each month for which payment is due into an account designated by DBP.

Section 6.3 Payment to Dental Providers. Payment to a Dental Provider for Dental Services shall be made pursuant to DBP's agreement with the Dental Provider.

Section 6.4 Adjustment to DBP Fees. After the initial and each subsequent term of this Agreement, the fees paid to DBP for DBP Services and Dental Services, as established in the DBP and Dental Services Description and Fee Appendix shall be renegotiated.

With respect to fees for services provided to members covered under Benefit Contracts, the parties shall initiate negotiations at least one hundred and twenty (120) days before the expiration of the then current term of this Agreement. Any renegotiated rates shall become effective on the first date of the new term of this Agreement, unless the parties agree otherwise, regardless of the date on which the new fees are established by agreement or litigation. If the parties have not successfully renegotiated all fees within sixty (60) days of the beginning of the new term of this Agreement, the parties shall comply with Section 11.7 before initiating any formal legal action.

Section 6.5 Payment in Full. DBP shall require Dental Providers to accept as payment in full for Dental Services provided to Members such amounts as are paid pursuant to agreements with Dental Providers. Dental Providers may collect Member Expenses from the Member.

Section 6.6 Member Protection. This Section applies when any applicable statutes and regulations require that the Member be held harmless from any and all costs, which are the legal obligation of DBP or GLHP.

DBP shall require Dental Providers to accept as payment in full for Dental Services provided to Members such amounts as are paid pursuant to this Agreement and/or the agreements with the Dental Providers. In no event, including, but not limited to, non-payment for Dental Services provided to Members; insolvency of DBP or GLHP; or breach by GLHLP of any term or condition of this Agreement or breach by DBP of any term or condition of the agreement with the Dental Provider, shall DBP or the Dental Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Dental Services eligible for reimbursement under this Agreement.

The provisions of this Section shall: (1) apply to all Dental Services provided while this Agreement is in force; (2) with respect to Dental Services provided while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between a Dental Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such Dental Services.

Section 6.7 Coordination of Benefits and Subrogation for Full Service Members. Any and all amounts recovered by DBP for Dental Services through the coordination of benefits or subrogation shall be retained by DBP.

Article 7
Responsibility for Damages and Insurance; Representations and Warranties

Section 7.1 Responsibility for Damages. Each party shall be responsible for any and all damages, claims, liabilities or judgments which may arise as a result of its own gross negligence or intentional or willful wrongdoing. Any costs for damages, claims, liabilities or judgments and any related reasonable expenses that are incurred at any time by one party or any of its affiliates (the "Indemnitee) as a result of the gross negligence or intentional or willful wrongdoing of the other party (the "Indemnitor") or its employees shall be paid for or reimbursed by the Indemnitor.

The Indemnitor may, at its election and upon the giving of timely notice to Indemnitee, assume charge of any investigation, defense or settlement of any claim made or suit brought against the Indemnitee, but Indemnitee, at its option, shall have the right and shall be given the opportunity at its own expense, to associate with the Indemnitor in the investigation, defense or control of such claim or suit, and the Indemnitor shall make no settlement without consent of the Indemnitee, which consent shall not be unreasonably withheld. This provision shall survive the termination of this Agreement.

Notwithstanding the preceding, DBP shall not be liable for the cost of any dental care or treatment that an arbitrator, jury, judge or other decision-maker determines are Dental Services unless the Member was a Full Service Member at the time the services were provided or requested.

Section 7.2 Provider Liability Insurance. DBP shall require Dental Providers to procure and maintain malpractice and/or professional liability insurance equal to the prevailing community standard unless state law requires otherwise, or unless a Participating Organization provides notice in advance of implementation of other insurance requirements.

Section 7.3 GLHP's Insurance. GLHP, at its sole cost and expense, shall procure and maintain comprehensive general liability, professional liability and other necessary insurances to insure GLHP and its employees, acting within the scope of their duties, against claims for damages arising by reason of personal injury or wrongful death occasioned directly or indirectly by GLHP or by its employees in connection with the performance of GLHP's responsibilities under this Agreement.

DBP, at its sole cost and expense, shall procure and maintain comprehensive general liability, professional liability and other necessary insurances to insure DBP and its employees, acting within the scope of their duties, against claims for damages arising by reason of personal injury or wrongful death occasioned directly or indirectly by DBP or by its employees in connection with the performance of DBP's responsibilities under this Agreement.

Section 7.4 Representations and Warranties. DBP and GLHP each represents and warrants that each of the following statements is true and correct as of the Effective Date of this Agreement:

(a) **Due Organization**. Such party is duly organized and validly existing under the laws of the jurisdiction of its organization and has all requisite power and authority to execute and deliver this Agreement and carry on its business as now being conducted by it, and is in good standing or duly registered with the appropriate authority in each jurisdiction in which the nature of business conducted therein by it requires it to be qualified therein to do business.

(b) **Authority**. Such party has taken all action necessary for the authorization, execution, delivery and performance of this Agreement, and each of this Agreement has been duly executed and delivered by such party and, when executed by the other party, constitutes the valid and binding obligation of such party, enforceable in accordance with its terms, except as such enforcement may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or other laws of general application affecting enforcement of creditors' rights.

(c) **No Conflict**. Neither the execution nor delivery of this Agreement; nor the consummation of the transactions contemplated by this Agreement, nor the fulfillment of or compliance with the terms and conditions of this Agreement will conflict with any law, order, judgment or decree applicable to such party or with such party's charter documents, or result in a breach of or constitute a default under or conflict with any material contract, agreement or instrument to which such party is a party or by which it or its properties are bound.

Article 8
Regulatory Compliance

Section 8.1 Laws, Regulations, Licensure. DBP shall and shall require each Dental Provider and all health care professionals employed by or under contract with such Dental Provider to maintain all federal, state and local licenses, certifications and permits, without material restriction, that are required to provide the services DBP and Dental Provider are obligated to provide under this Agreement, and shall comply, in all material respects, with all applicable statutes and regulations.

GLHP shall maintain all federal, state and local licenses, certifications and permits, without material restriction, that are required to perform the business and services contemplated by this Agreement, including the issuance of Benefit Contracts, and shall comply, in all material respects, with all applicable statutes and regulations.

Section 8.2 Regulatory Filing. In the event that GLHP is required to file this Agreement with federal, state or local governmental authorities, GLHP shall be responsible for filing the Agreement with such authorities as required by any applicable law or regulation. If, following any such filing, the governmental authority requests changes to this Agreement, DBP and GLHP shall jointly discuss the response to the governmental authority. In the event any federal, state or local governmental authority requires a change to this Agreement that DBP and GLHP deems to be material, the party may request re-negotiation of the affected provisions of this Agreement pursuant to Section 11.9 of this Agreement.

Section 8.3 Delegation of Activities. As required by law or applicable accreditation standards, the parties to this Agreement agree to amend this Agreement or enter into additional agreements that provide for the delegation of activities from GLHP to DBP. The activities to be delegated may include, but are not limited to, credentialing and quality.

Article 9
Books and Records

Section 9.1 Maintaining Records. DBP shall maintain records that are usual and customary for the DBP Services in accordance with all applicable statutes and regulations. Any such records shall remain the property of DBP, subject to any rights of Members or unless otherwise required by law.

Section 9.2 Privacy and Release of Records. DBP and GLHP and any Dental Network Customers shall maintain the confidentiality of all information regarding Members in accordance with any applicable statutes and regulations, including the HIPAA Privacy Standards.

Upon request by and at the expense of, GLHP, DBP shall obtain all applicable information and records or copies of records regarding DBP Services provided by a Dental Provider to a Member and shall release such information to GLHP.

During and after the term of this Agreement, GLHP and its related entities may use and transfer any and all information gathered under this Agreement for research and analytical purposes in accordance with applicable law.

Section 9.3 Member Access to Records. DBP shall establish and maintain procedures to ensure timely access by Members to medical records and other health information in DBP's possession that pertain to them, in accordance with applicable law, including the HIPAA Privacy Standards and the regulations applicable to Benefit Contracts for Medicare Members.

Section 9.4 Examination of Records. Upon reasonable notice, during normal business hours and at a reasonable time and place, any party, shall have the right to examine any records of any other party that relate to such party's obligations under this Agreement, including, without limitation, any records relating to the compensation owed DBP under this Agreement. All records maintained by any party relating to its responsibilities under this Agreement shall be kept for at least seven years after the date the records were created or any applicable period required by law, regulation or CMS, whichever is longer. A party shall pay the cost of copies of any records that it requests from another party.

If a party examines the records of another party, the examining party shall pay the examined party:

(a) the examined party's reasonable employee costs related to the examination if such examination requires in excess of 16 hours of the examined party's employees' time, and

(b) any other reasonable costs incurred by the examined party in complying with the examination request.

Subject to Section 9.6, no third party may conduct an examination without the prior written consent of the examined party.

Section 9.5 Audits and Corrective Action Plans. GLHP shall provide DBP with a report of any audit findings resulting from an examination by it under Section 9.4 within 15 business days of the conclusion of an audit. In the event deficiencies are noted during the audit, DBP shall develop a corrective action plan. Such plan shall be subject to GLHP's approval (which shall not be unreasonably withheld), shall include specifics of and timelines for correcting deficiencies, and shall be provided to GLHP within 15 business days of GLHP's report of its findings. GLHP shall approve or disapprove the corrective action plan within five business days of receipt of the corrective action plan. The approved corrective action plan shall be implemented by DBP within the specified timeframes. In the event the corrective action plan is not implemented to the reasonable satisfaction of GLHP, delegation of any or all delegated activities may be revoked pursuant to Section 10.7 of this Agreement.

Any disputes regarding the GLHP's determination regarding a deficiency and/or the adequacy of DBP's corrective action plan may be resolved pursuant to Section 11.7.

Section 9.6 Government and Accrediting Agency Access to Records. Federal, state and local government and accrediting agencies, including, but not limited to, the Secretary of Health and Human Services, the Comptroller General, or any of their authorized representatives, shall have access to, and GLHP and DBP are authorized to release all information and records or copies of such within their possession that are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to GLHP or DBP.

Article 10
Term and Termination

Section 10.1 Term of the Agreement. This Agreement is for an initial term starting on the Effective Date and ending on December 31, 2005. It shall automatically renew for additional one-year terms until either party terminates this Agreement pursuant to Section 10.2.

Section 10.2 Termination of the Agreement. This Agreement may be terminated as provided below.

(a) GLHP may terminate this Agreement as follows:

(1) effective upon 120 days advance written notice to DBP ;

(2) at any time, in the event of material breach by DBP, upon at least 90 days prior written notice to DBP, unless the material breach has been cured or a reasonable corrective action plan has been developed and approved by GLHP, such approval shall not be unreasonably withheld, before the end of the 90-day notice period;

(3) immediately, upon written notice to DBP, due to DBP's loss or suspension of material licensure or certification, or loss of insurance.

(4) pursuant to Section 11.8 or 11.9; or

(5) upon a Change in Control of DBP (other than a Change in Control in which UnitedHealth Group Incorporated, directly or indirectly, holds more than 50% of the outstanding voting securities or other equity interests of DBP) upon at least 180 days prior written notice to DBP.

(b) DBP may terminate this Agreement as follows:

(1) effective upon 120 days advance written notice to GLHP;

(2) at any time, in the event of material breach by GLHP, upon at least 90 days prior written notice to GLHP, unless the material breach has been cured or a reasonable corrective action plan has been developed and approved by DBP, such approval shall not be unreasonably withheld, before the end of the 90 day notice period;

(3) pursuant to Section 11.8 or 11.9;

(4) upon at least 30 days, or such greater amount of time permitted by the state regulator, if DBP is found to be subject to state or local licensing or other regulatory requirements that substantially burden or increase of the cost of providing services under this Agreement or which require DBP to obtain licensure as an insurer, health maintenance organization, health service plan or other similar license; or

(5) upon a Change in Control of GLHP (other than a Change in Control in which UnitedHealth Group Incorporated, directly or indirectly, holds more than 50% of the outstanding voting securities or other equity interests of United or such Participating Organization, as the case may be), upon at least 180 days prior written notice to GLHP.

Upon notice of termination of this Agreement given by one party to another, GLHP shall pay all fees owed to DBP under this Agreement and DBP shall provide DBP Services until the effective date of the termination.

Section 10.3 Effect of Expiration or Termination. When this Agreement expires pursuant to Section 10.1 or is terminated pursuant to Section 10.2, the parties agree as follows:

(a) **Transition and Cooperation.** DBP will cooperate with GLHP and/or GLHP's designee to transition the care and management of Members in treatment on the date of expiration or termination. DBP and GLHP's designee will work together to transition business, medical, and management records to GLHP or GLHP's designee in a commercially reasonable manner that reflects the rights and obligations of all parties, including DBP's need for ongoing access to such records.

(b) **Full Service Members Claims.** DBP is financially and administratively responsible for any claims for Dental Services provided prior to the expiration or termination date, even if the claim for such Dental Services is not received until after the expiration or termination Date. The applicable terms of this Agreement, including Article 5, apply to such claims.

DBP is also financially and administratively responsible for any claims for Dental Services provided after the expiration or termination date if the claim is related to completing Dental Services that started prior to the expiration or termination date. For example, completing a crown or root canal that was started, beyond examination, x-rays and recommendations, before the expiration or termination date. Completing such Dental Services is included in the Full Service Dental Payments DBP received prior to the expiration or termination date. The applicable terms of this Agreement, including Article 5, apply to such claims.

DBP is not financially or administratively responsible for any other claims for Full Service Members that are related to Dental Services provided after the expiration or termination date. DBP shall promptly forward any claims it receives for post-expiration or termination date Dental Services for Full Service Members that are not DBP's responsibility to GLHP or GLHP's designee in a manner consistent with any agreement reached pursuant to Section 10.3(a).

Section 10.4 Notice to Members. Upon final notice of termination of this Agreement, GLHP shall have the right, at their own expense, to notify Members of such termination.

Section 10.5 Continued Provision of Health Services After Termination. DBP agrees that in the event this Agreement is terminated, DBP shall use commercially reasonable efforts to cause Dental Providers to continue to provide Dental Services to any Members undergoing treatment at the time of such termination until the earlier of:

(a) the current episode of treatment is completed;

(b) arrangements are completed for such Members to be transferred to another dental provider; or

(c) until 30 days after the termination date of this Agreement.

DBP and Dental Providers shall be reimbursed in accordance with Section 10.3 for all such Dental Services rendered subsequent to the termination of this Agreement.

Section 10.6 Revocation of Certain Delegated Activities. GLHP retains the right to revoke the delegation of any delegated activity without terminating the entire Agreement as follows:

(a) at any time upon at least 120 days prior written notice to DBP; or

(b) in the event that GLHP's audit report identifies material deficiencies, provides written notice to DBP of such material deficiencies and DBP fails to:

(i) develop a mutually agreeable and satisfactory corrective action plan;

(ii) implement a corrective action plan pursuant to mutually agreed upon timelines; or

(iii) correct the identified deficiencies after implementing the corrective action plan pursuant to Section 9.5.

Article 11

Miscellaneous

Section 11.1 Assignment. Except as provided in this Section 11.1, no party may assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of the other parties, which shall not be unreasonably withheld. All parties to this Agreement acknowledge that persons and entities under contract with or affiliated with them may perform certain administrative services under this Agreement. The parties acknowledge that an assignment of all or any of one party's rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with that party shall not require the other party's prior written consent.

Section 11.2 Entire Agreement and Amendment. This Agreement, which incorporates all exhibits, attachments, addenda, and appendices to it, constitutes the entire agreement among the parties in regard to its subject matter. This Agreement may be amended only by a written amendment executed by the affected parties, except that GLHP may amend this Agreement unilaterally to comply with the requirements or state and federal regulatory authorities, subject to

Sections 12.8 and 12.9, and shall give written notice to DBP of such amendment and its effective date. With regard to its subject matter, this Agreement specifically supercedes any existing agreements between DBP and GLHP.

Section 11.3 Use of Names. During the term of this Agreement, all parties to this Agreement shall have the right to designate and make public reference to "Dental Benefit Providers", or "DBP" by name in an accurate, factual manner, as the company managing and/or arranging for the provision of Dental Services. DBP shall have the right to make public reference to GLHP and all other parties to this Agreement and to the Participating Organization Addenda by name in the course of identifying itself as the company managing and/or arranging for the provision of Dental Services. DBP and GLHP shall not otherwise use another party's name, trademarks, or service marks without prior written approval.

Section 11.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Michigan, without regard to the conflicts of laws provisions thereof.

Section 11.5 Notices. Any notice under this Agreement shall be hand delivered or sent by reputable overnight courier, or registered or certified mail to the signatories and addresses listed on the signatory page or otherwise identified on any affected Addenda. The individuals and addresses to which notices are sent may be changed by proper written notice. Notices shall be deemed effective (a) as of the date received if hand delivered, (b) one business day after sending if sent by overnight courier, (c) three days after sending if sent by registered or certified mail.

Section 11.6 Compliance with Laws. All parties to this Agreement shall comply, in all material respects, with all applicable laws and regulations, including but not limited to all applicable Medicaid laws, regulations and CMS instructions; Title VI of the Civil Rights Act of 1964;the Age Discrimination Act of 1975; and the Americans with Disabilities Act. DBP shall use commercially reasonable efforts to require all Dental Providers comply with this provision.

Section 11.7 Resolution of Disputes. In the event a dispute arises relating to this Agreement, the parties shall, prior to the initiation of any formal dispute resolution process or litigation meet and confer in good faith in an attempt to resolve the dispute.

Section 11.8 Change in Law. If any federal, state or local law, rule, regulation, policy or any interpretation thereof (including, without limitation, any court order or ruling) at any time during the term of this Agreement:

(a) has a material and adverse effect on the ability of a party to receive the benefits it reasonably expects to obtain under this Agreement; or

(b) renders it illegal for a party to continue to perform under this Agreement in a manner consistent with the parties' intent,

then the parties to this Agreement shall negotiate in good faith to amend this Agreement to bring it into compliance, while at the same time preserving the economic expectations of the parties, to the greatest extent possible.

If this Agreement is not amended in writing within 60 days of one party notifying the other party of a compliance issue pursuant to this Section 11.8, the notifying party shall have the right to terminate this Agreement upon 30 days prior written notice to the other party. Any such notice of termination must be given within 15 days of the end of the 60-day renegotiation period.

Section 11.9 Renegotiation of this Agreement. Except as provided in Section 11.8, the affected parties shall renegotiate this Agreement if any party would be materially adversely affected by continued performance as a result of a significant reduction in the number or change in the composition of Member enrollment, a change in a law or regulation or interpretation thereof, a change in benefits, coverage, policy, utilization, trends, or other significant change, or a requirement that either party comply with an existing law or regulation contrary to the party's prior reasonable understanding which represents a fundamental departure from the risk assumptions and the intent of the parties in entering into this Agreement or any Addenda.

The affected party must promptly notify the other parties of the change or compliance requirement and its desire to renegotiate this Agreement or Addendum. If a new agreement or Addendum is not executed within 60 days of the receipt of the renegotiation notice, the party adversely affected shall have the right to terminate this Agreement and/or Addendum upon 30 days prior written notice to the other parties. Any such notice of termination must be given within 15 days of the end of the 60 day renegotiation period.

Section 11.10 Confidential Business Information. All parties to this Agreement shall take all reasonable steps to protect the other parties's Confidential Information. For the purposes of this Agreement, a party's "Confidential Information" shall include all information and records provided to another party under this Agreement, including, without limitation, such party's customer lists and patented, trademarked, trade-named, service-marked or copyrighted material or property; provided, however, that Confidential Information shall not include:

(a) any information lawfully in the receiving party's possession, other than under an obligation of confidentiality, prior to the date of disclosure thereof by the disclosing party,

(b) any information which is in the public domain or hereafter becomes a part thereof through no fault of the receiving party,

(c) any information that becomes available to the receiving party on a non-confidential basis from a source, other than the disclosing party, that is not obligated to the disclosing party not to disclose such information, or

(d) any information that is independently developed by the receiving party without reference to or use of the Confidential Information..

Except as allowed pursuant to this Agreement or as permitted by the written consent of the disclosing party, no party shall:

(a) disclose another party's Confidential Information to third parties; or

(b) utilize any Confidential Information of another party.

Promotional videos may be rebroadcast and brochures made available via GLHP's or other applicable parties' intranet solely for the purpose of providing information about DBP Services to Members, provided such materials contain an appropriate copyright acknowledgment.

Section 11.11 Excluded Individuals. DBP shall not employ or contract with an individual who is excluded from participation in Medicare under Section 1028 or 1128A of the Social Security Act (or with an entity that employs or contracts with such an individual) for the provision of care or administrative services for Members who are enrolled in a federal health care program, including but not limited to Medicare and Medicaid.

Section 11.12 Financial Solvency. As periodically requested by GLHP, DBP shall make available to GLHP, or to a third-party auditor retained by GLHP, financial or other information pertinent to DBP's ability to meet its financial obligations under this Agreement.

Section 11.13 Non-waiver. The failure of either party to insist upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy.

Section 11.14 Relationship Between Parties. The relationship between the parties to this Agreement and is solely that of independent contractors. Nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

Section 11.15 Survival of Terms. Any provisions of this Agreement which, by their nature, extend beyond the expiration, or termination of this Agreement, shall survive the termination of this Agreement, and shall remain in effect until all such obligations are satisfied.

Section 11.16 No Third Party Beneficiaries. This Agreement and Addenda are intended solely for the benefit of the parties hereto and no third parties shall have any rights hereunder or interest herein except as provided in Section 6.5.

Section 11.17 Press Releases. The parties mutually agree to provide advance notice and opportunity to comment on all media releases and communications regarding this Agreement.

DENTAL BENEFIT PROVIDERS, INC. 800 King Farm Boulevard, Suite 600 Rockville, MD 20850	**GREAT LAKES HEALTH PLAN, INC.** 17117 West Nine Mile Road - #1600 Southfield, MI 48075
By _____	By _____
_____	Print Name _____
_____r	Print Title _____
Date _____	Date _____

Great Lakes Health Plan - DBP and Dental Services Description and Fee Appendix

EFFECTIVE DATE: JULY 1, 2005

Product Identifier	Description of Dental Services (Include Benefit Contract reference as appropriate)	Full or Limited Service	Rate	Effective Date
Medicaid	Dental Services, as set forth in the Description of Covered Service Area and Services, for GLHP Enrollees Ages 21 and Over Residing in the Michigan counties of Wayne, Oakland or Macomb, only.	Full	$1.23 PMPM For GLHP Members Ages 21 and Over Who Reside in the counties of Oakland, Macomb or Wayne, only.	July 1, 2005

DESCRIPTION OF COVERED SERVICE AREA AND SERVICES

1. For purposes of this Agreement, "Member" shall mean those GLHP Members who: (a) reside in the Michigan counties of Wayne, Oakland or Macomb Counties, only; (b) are 21 years of age and older; and (c) who is eligible for and properly enrolled for dental benefits through GLHP.

2. For purposes of this Agreement, neither DBP nor a DBP Dental Provider shall require a Member who seeks or is furnished a Covered Service a Co-payment, Coinsurance or a Deductible as such terms are defined under this Agreement.

3. DBP will provide the following Covered Services:

   a. ADA Code - 0120 Periodic Oral Evaluation: One per year - any combination of;

   b. ADA Code - D0120 and D0150 Comprehensive Oral Evaluation: Once per 3 years - maximum of two per year for any combination of;

   c. ADA Code - D0120 and D0150 0272 Bitewing: two films One 272/273/274 per year;

   d. ADA Code - 0274 Bitewing - four films One 272/273/274 per year; and

   e. ADA Code - 1110 Adult Prophylaxis: One per year.

ERIC: Any way we can get some clarification on these services. I understand the codes and procedures, but some of the limitations are difficult to understand.

Medicaid Appendix

Michigan Statutory and Regulatory Requirements for Medicaid Product

This Michigan Regulatory Requirements Appendix (the "Appendix") supplements and is made part of the Agreement concerning between Dental Benefit Providers, Inc. ("DBP") and the Practice named in the Dental Provider Agreement. The Practice acknowledges and agrees that the provisions of this Appendix apply to both the Practice and each Participating Dentist, and shall cause each Practice and Participating Dentist to comply with these.

This Appendix applies to the Michigan health maintenance organization ("HMO") Medicaid product.

Capitalized terms used but not defined in this Appendix shall have the meaning ascribed to them in the Agreement.

Provisions applicable to the Benefit Plan regulated under Michigan HMO laws or Medicaid rules or guidelines:

1. **Non-Discrimination.** The Practice shall not discriminate against any Patient based upon the frequency or extent of Covered Services needed by the Patient. The Practice shall not unlawfully discriminate in the acceptance or treatment of Patients because of their religion, race, color, national origin, age, sex, height, weight, marital status or physical handicap.

2. **Governmental Agency Access.** The Practice shall permit the authorized government and regulatory agencies, to periodically conduct on-site evaluations of the Practice's records in accordance with the terms of the Agreement and current state and federal laws and regulations. The Practice further agrees to comply with those agencies' recommendations, if any. DBP shall give the Practice reasonable notice of its intent to conduct a site visit and will give the Practice reasonable notice of any agency's plans to conduct a site visit, if DBP receives such notice. The Practice shall further submit to dental audits conducted at the discretion of authorized government and regulatory agencies, which may include the copying of dental records or claims of Patients , as related to the standard of dental practice, billing and claims practice, and quality of care provided to all Patients. Such audits are to be performed periodically, under the direction of a licensed dentist(s), as required by appropriate federal or state regulatory agencies. The Practice agrees to furnish copies of the dental and claims records at no charge.

3. **Continuity of Care After Termination of Agreement.** The Practice agrees that in the event the Agreement is terminated, that the parties shall agree to a continuity of care treatment plan, as required, for Patients who received a 90-day notice from the Practice of the Practice's termination with DBP.

4. **Confidentiality.** DBP and the Practice agree that the dental records of Patients shall be treated as confidential so as to comply with all federal and state laws and regulations regarding the confidentiality of medical records.

5. **Cooperation with Plan Quality Protocols**. The Practice shall provide Covered Services in a manner consistent with generally accepted medical practice standards and further agrees to cooperate with DBP's policies and procedures for quality management ("QM") and utilization review ("UR"). The Practice agrees to perform QM and UR in accordance with the requirements of state and federal law and to participate in any QM and UR programs established by DBP. The Practice recognizes DBP's right to assure that all QM, UR, benefit determination, and related administrative services inherent and necessary in a managed health care system comply with applicable State and federal regulatory requirements and applicable legislation. The Practice acknowledges that it may be subject to retroactive denial of payment or recoupment of payments made by DBP to the Practice for Covered or non-Covered Services if (1) the Practice's services were not authorized by DBP and for which authorization was required; (2) if the Practice's services were falsely or fraudulently billed; or (3) if DBP suspends continued authorization based upon QM and UR activities. The Practice shall comply with all final payment determinations made by DBP.

6. **Grievances.** DBP shall notify Practice concerning all Patient complaints involving it and Practice shall notify DBP of any complaint received from Patients. Practice shall use good faith efforts to investigate such complaints, and in consultation with DBP, shall use its best efforts to resolve them in a fair and equitable manner. Practice shall participate in and cooperate with DBP's grievance procedure and comply with all final determinations provided in accordance with that procedure. A copy of DBP grievance procedure shall be provided to Patient, at the time of enrollment and to the Practice upon execution of this Agreement. This paragraph shall survive termination of this Agreement.

7. **Additional DBP Obligations**. DBP shall adhere to the following obligations as may be required by federal or state law:

   a. DBP shall not prohibit the Practice from discussing treatment options with Patients that may not reflect DBP's position or may not be covered by Patient's health benefit plan.

   b. DBP shall not prohibit the Practice from discussing financial arrangements between DBP and the Practice.

   c. DBP shall not prohibit the Practice from advocating on behalf of the member in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.

   d. DBP shall not discriminate with respect to participation, reimbursement or indemnification as to any Participating Dentist

who is acting within the scope of the Practice's license or certification under applicable state law, solely on the basis of such license or certification. However, the foregoing provision should not be construed as an "any willing provider" clause, as it does not prohibit DBP from limiting the Practice to the extent necessary to meet the needs of the Patients. The Practice acknowledges that the foregoing provision does not interfere with measures established by DBP that are designated to maintain quality and control costs consistent with the responsibility of the organization.

8. **Governmental Requirements.** The Practice shall maintain complete and accurate fiscal records, as well as dental records, applying solely to Patients for whom the Practice has claimed and received payment. The Practice shall maintain such records as are necessary for the evaluation of the quality, appropriateness and timeliness of service performed under this Agreement. Said records will be made available for fiscal audit, medical audit, medical review, QM, UR, and other periodic monitoring upon request of authorized representatives of DBP and authorized federal and state regulating agencies. Dental records or copies shall be provided upon request of DBP or authorized federal and state regulating agencies. The Practice further agrees to comply with requirements issued as a result of any such inspection or audit. Said records shall be retained for a period of at least six (6) years after the starting date of the applicable retention period and further pending the resolution of any ongoing audit.

9. **Hold Harmless**. The Practice and each Participating Dentist must look solely to DBP for payment of Covered Services provided to Patients pursuant to the Agreement, and will hold the Michgian Department of Community Health and Patients harmless in the event that DBP cannot or will not pay for such Covered Services. Neither the Practice nor any Participating Dentist may require any copayment or cost sharing for Covered Services provided under the Agreement. Neither the Practice nor any Participating Dentist may charge Patients for missed appointments. This provision shall survive any termination of the Agreement, including breach of the agreement due to insolvency. The Practice and each Participating Dentist must indemnify and hold the MDCH and Patients harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising in connection with the Agreement. This clause survives the termination of the Agreement, including breach due to insolvency.

10. **Clean Claim and TPL**. DBP agrees to pay the Practice pursuant to MCL 400.111i; 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable. If a third party liability exists, payment of claims shall be determined in accordance with MDCH requirements. Unless DBP otherwise requests assistance from the

Practice. DBP will be responsible for third party collections conducted in accordance with MDCH guidelines.

11. **Continuation of Service**. In addition to the duration specified in the Agreement, the Practice and each Participating Dentist must continue to provide services through the term of the capitation period for which the payor has paid GLHP.

12. **Compliance with Michigan Medicaid Contract**. All tasks performed under the Agreement must be performed in accordance with the payor's Medicaid contract with the State of Michigan, the provisions of which are incorporated into the Agreement as applicable. If any provision of the Agreement is in conflict with provisions of such Medicaid contract, the terms of the Agreement in conflict with those of the Medicaid contract will be considered waived.

13. **Payment Rate**. The Practice and each Participating Dentist must not charge for any service provided to the Member at a rate in excess of the rates established by the Agreement in accordance with Section 1128B(d)(1), Social Security Act (enacted by Section 4704 of the Balanced Budget At of 1997).

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

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

May 11, 2005

CHANGE NOTICE NO. 4
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075** **Csherer@glhp.com**	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 **N/A**	SHIPMENT **with three 1 year renewal options** **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE (S):

Effective immediately, the attached subcontractors agreement with Leade Health is hereby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and vendor contact (Rose Myers) dated 4/13/05.

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

Great Lakes

April 13, 2005

Ms. Irene Pena, CPPB
DMB Acquisition Services
Mason Building, 2nd Floor
530 West Allegan
Lansing, MI 48933

Dear Ms. Pena:

In accordance with the contract with the State of Michigan and Great Lakes Health Plan ("GLHP"), I am submitting for your review, a contract for a sub-contractor that was not part of the original Invitation to Bid.

GLHP wishes to contract the services of Leade Health, Inc. ("LHI") to conduct a smoking cessation program for GLHP Medicaid members. LHI currently has a contract with the State of Michigan for smoking cessation for the Fee-For-Service Medicaid population.

All required information is attached including, but not limited to:

- Subcontractor Name
- Associated Fees
- Description of Services to be Performed

As you will notice, the effective date of the contract is May 10, 2005 which is within the 21 day required notice to you.

Please contact me if you have any questions or concerns at 248.331.4357 or rmyers@glhp.com.

Sincerely,

Rose Myers
Government Programs Liaison

cc: Darryl Bragg, Department of Community Health

Service Agreement
Between GREAT LAKES HEALTH PLAN, INC. and Leade Health, Inc (LHI).

This Services Agreement ("Agreement") is entered into by and between **GREAT LAKES HEALTH PLAN ("GREAT LAKES")**, a health maintenance organization authorized to operate in the state of Michigan and **LEADE HEALTH, INC. ("LHI")**, a Michigan corporation. This Agreement is effective as of May 10, 2005 ("Effective Date").

I. RECITALS

WHEREAS, Great Lakes is contracted by the State of Michigan through the Michigan Department of Management and Budget and the Michigan Department of Community Health to deliver comprehensive health care benefits to Medicaid recipients;

WHEREAS, GREAT LAKES desires LHI to plan, manage, implement, and evaluate a Tobacco Cessation Program for persons enrolled in the GREAT LAKES benefit programs ("Members"); and

WHEREAS, the parties desire to set forth their respective duties, responsibilities, and obligations to each other;

NOW, THEREFORE, in consideration of the premises and conditions in this Agreement, it is agreed between the parties as follows;

II. DEFINITIONS

A. "Effective Date" means the date stated in the first paragraph of this Agreement.

B. "Member" means a Member of GREAT LAKES as that term is defined in a GREAT LAKES Subscriber Agreement or similar evidence of coverage.

C. "Party" means GREAT LAKES or LHI.

D. "Program" means the LHI I Can Quit Tobacco Cessation Program model provided to state of Michigan residents via the Michigan Quit Line.

III. SERVICES TO BE PROVIDED BY LHI

A. LHI shall provide GREAT LAKES with a project plan to implement the Program. The implementation plan shall include, but not be limited to milestones for notification, and a process work flow illustrating the Program operations. Sample documents of Member and physician communications will also be provided for

GREAT LAKES' review and customization. LHI shall provide the Program instructing Members of GREAT LAKES in accordance with Exhibit A entitled "Leade Health's I Can Quit Tobacco Cessation Services and Fees" and any additional work plans jointly developed by LHI and GREAT LAKES.

B. LHI shall initially offer GREAT LAKES Members a proactive telephonic tobacco cessation call model as more fully described in Exhibit A.

C. Members of GREAT LAKES will access the Program via the toll free number established for the State of Michigan Quit Line. This toll free line shall be maintained by LHI at all times. Members may also access Programs through e-enrollment or other processes mutually acceptable to LHI and GREAT LAKES. LHI and GREAT LAKES will establish links to access e-enrollment forms.

D. LHI will verify GREAT LAKES Member eligibility prior to Program enrollment via a mutually agreed upon reasonable and easily administered verification process. GREAT LAKES shall provide the LHI Account Manager with written instructions regarding this process prior to Program implementation.

E. LHI will coach and follow-up on all Members who participate in the Program in accordance with services outlined in the Exhibit A.

F. LHI shall provide two (2) Outcomes Reports per year provided at least 30 Members have enrolled in the Program during the 6 month period prior to the Report compilation date. The first Outcomes Report will be generated during the eight (8th) month following the first month of Program enrollment. Subsequent Outcomes Reports will be generated every 6 months thereafter. Each Outcomes Report will be delivered on or before the 15th of the month due. The first Outcomes Report will provide participant demographic and enrollment trend data. Subsequent Outcomes Reports will provide outcomes and cost savings data when the sample size for these measures $\geq$ 30. GREAT LAKES may request such other reports as regulatory oversight may require. The fee for other reports will be provided at the consulting fees rates quoted in Exhibit A.

G. LHI shall provide progress notes to each Member's physician upon enrollment and following contact at 6 and 12 months post Program enrollment.

H. LHI shall provide all services in accordance with GREAT LAKES' benefits, policies and procedures on tobacco cessation. GREAT LAKES shall provide the LHI Account Manager with this information in writing prior to Program implementation.

I. <u>Cooperation of Customization as needed.</u>
In the event that the parties conclude that the GREAT LAKES implementation of the

Program requires customization, LHI will cooperate with GREAT LAKES to attempt to provide such customizations as mutually agreed upon in an amendment to this agreement at the consulting fees rates quoted in Exhibit A.

J. Compliance with laws and regulations

Each of the parties hereto shall abide by all applicable state and federal laws and regulations that pertain to them, including all applicable laws, regulations and instructions published from time to time by the Centers for Medicare and Medicaid Services ("CMS"). If this Agreement or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

K. Non-recourse against Members.

LHI shall not, in any event, including but not limited to non-payment by GREAT LAKES, the insolvency of GREAT LAKES, or breach of this Agreement, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member for Program services rendered pursuant to this Agreement. LHI further agrees that:

1. This provision shall survive the termination of this Agreement, regardless of the reason giving rise to termination; and

2. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between LHI and a Member or persons acting on behalf of a Member.

IV. CONFIDENTIALITY & NON-SOLICITATION

A. CONFIDENTIALITY AGREEMENT

In consideration of the opportunity to exchange information considered by LHI and GREAT LAKES to be confidential and proprietary ("Confidential Information" as described in Section IV.B), the parties agree: (1) to maintain in confidence all such Confidential Information acquired from each other; (2) not to provide, or to disclose, or otherwise make available any Confidential Information to anyone except their officers, directors, employees, counsel, advisors, and other agents (collectively "Representatives") who are required to have such Confidential Information in order to perform their functions in connection with the limited purpose of this Agreement; (3) to ensure that each of its permitted Representatives to whom Confidential Information is disclosed shall adhere to all aspects of this Agreement; (4) not to use the Confidential Information for any purpose other than for which it is disclosed; and (5) to protect the other Party's Confidential Information with the same degree of

reasonable care it employs to protect its own Confidential Information.

Anything to the contrary contained in the preceding paragraph, notwithstanding, if either Party receives a request under a subpoena or order issued by, or in conjunction with, a litigation pending with a court of competent jurisdiction or a governmental body, to disclose all or any part of the Confidential Information, the Party receiving said order shall, to the extent lawful, (1) immediately notify the other Party hereto of the existence, terms and circumstances surrounding such a request, (2) consult with the other on the advisability of taking legally available steps to resist or narrow such request, (3) if disclosure of such Confidential Information is required, furnish only that portion of the Confidential Information which, in the opinion of counsel, is required to be disclosed, and (4) use its best efforts to permit the other to obtain an order or other reliable assurance that confidential treatment will be accorded to such disclosed Confidential Information.

B. CONFIDENTIAL INFORMATION

"Confidential Information" includes without limitation: (1) matters of a technical nature such as trade secret processes or devices, know-how, data, formulae, inventions (whether or not patentable or copyrighted), specifications and characteristics of products planned or being developed, and research subjects, methods and results; (2) matters of a business nature such as information about costs, profits, pricing policies, markets, sales, suppliers, customers, product plans, and marketing plans or strategies; (3) information received from third parties under an obligation of confidentiality, and (4) other information of a similar nature not generally disclosed to the public.

Each Party acknowledges the Confidential Information may include information relating to subsidiaries, vendors, customers, providers, Members and others, as well as information relating to the parties themselves.

The obligations imposed by this Agreement shall not apply to any information that:

(a) is rightfully received from a third party without accompanying use or disclosure restrictions;

(b) is independently developed by representatives of the receiving Party who has not had access to such Confidential Information;

(c) is or becomes publicly available through no wrongful act of the receiving Party;

(d) is already known to the receiving Party as evidenced by documentation bearing a date prior to the date of disclosure; or

(e) is approved for release in writing by an authorized representative of the other Party.

The Party seeking to assert the above exclusions shall bear the burden of showing that the foregoing exclusion(s) applies to any information or materials.

C. NON-PUBLIC PERSONAL FINANCIAL AND HEALTH INFORMATION

The Parties shall keep all non-public personal financial and health information in strictest confidence in accordance with all applicable law and regulation.

D. PROPERTY OF HEALTH CARE ORGANIZATION

All memoranda, notes, records, lists or other documents and all Confidential Information and non-public personal financial and health information made available to LHI by GREAT LAKES during the term of this Agreement concerning GREAT LAKES members shall at all times remain the property of GREAT LAKES and the same shall be delivered to GREAT LAKES immediately upon termination of this Agreement or at any other time upon specific request by GREAT LAKES. LHI shall not use for its own benefit or for the benefit of others, any proprietary information, knowledge or data acquired from GREAT LAKES during the term of this Agreement.

E. NON-SOLICITATION

During the term of this Agreement and for a period of one year following the termination or expiration of this Agreement, neither Party (except upon prior written consent of the other Party) shall directly or indirectly, itself, or through any individual, person or entity: (1) induce or attempt to induce away, or aid, assist or abet any other party or person in inducing or attempting to induce away from his or her employment or association with the other Party, any employee, independent agent or consultant of such other Party; or (2) solicit or attempt to hire any person who, at the time of termination or during the ninety (90) day period preceding termination of the Agreement, was employed by the other Party. Further, during the term of this Agreement and for a period of one year following the termination or expiration of this Agreement, LHI shall not directly or indirectly, solicit, induce or attempt to induce away, or aid, assist or abet any other party or person in soliciting, inducing or attempting to induce away from GREAT LAKES any GREAT LAKES Member.

F. COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS PERTAINING TO CONFIDENTIALITY.

LHI agrees to abide by all state and federal laws and regulations pertaining to confidentiality and disclosure of medical records or other health and enrollment information.

G. RECORDS

Ownership of records. All Member data information obtained by LHI from GREAT LAKES shall be the property of GREAT LAKES. All forms, report formats and other records pertaining to LHI's performance under this Agreement shall be the property of LHI. These records shall remain accessible for examination and audit by LHI, or GREAT LAKES for six years after the date of furnishing smoking cessation services, upon prior written notice, at reasonable intervals during the regular business hours of LHI.

Availability of records. In accordance with the provisions of 42 C.F.R. § 422.502(e), LHI agrees to make available upon the written request of the Secretary of the Department of Health and Human Services or of the Comptroller General or any of their duly authorized representatives, this Agreement and any other books, records and documents that are necessary to certify to the above-named the nature and extent of costs incurred by GREAT LAKES for the administrative services furnished by LHI for which payment may be made under Medicare, Medicaid or other reimbursement Programs. The obligation of LHI to make records available extends for six years after the furnishing of such services pursuant to this Agreement. In the event of a request by the Secretary or Comptroller General for access, LHI agrees to immediately notify and consult with GREAT LAKES concerning the response that will be made to such request.

H. SURVIVAL OF PROVISIONS

The provisions of this Article shall survive the expiration or early termination of this Agreement.

V. RELATIONSHIP BETWEEN GREAT LAKES AND LHI

A. Independent Status of Parties. In the performance of the terms and conditions of this Agreement by either Party, its agents, servants and employees, each Party is at all times acting and performing as an independent Party with respect to the other Party, and neither Party shall have or exercise any control or direction over the method by which the Party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act or omission of either Party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement shall be construed to make or render either Party, the agent, servant, or employee of, or the joint venture with, the other Party or its agents, servants or employees.

B. Mutual Cooperation. To the extent compatible with the separate and independent

management of each Party, GREAT LAKES and LHI, to the extent a conflict of interest is not created thereby, each Party shall cooperate with the other with respect to any action, suit or proceeding commenced against either Party by a person or entity not a Party hereto with respect to the subject matter hereof.

C. Nonexclusively. Both Parties shall have the right to enter into similar agreements with other persons and entities.

VI. RESPONSIBILITIES OF GREAT LAKES AND LHI

A. LHI shall perform all services agreed to by the Parties as described in Exhibit A. It is understood that GREAT LAKES retains all final authority and responsibility for the Program policies and promotion, and that LHI is empowered to act on behalf of GREAT LAKES in connection with the Program only as expressly stated in this Agreement, its attachments and amendments, or as agreed to in writing by GREAT LAKES and LHI. As necessary, GREAT LAKES and LHI shall jointly review and modify the services and any work plans. GREAT LAKES shall maintain oversight of the Program through review of the monthly Enrollment Reports and twice-yearly Outcomes Reports provided by LHI and shall advise LHI of its requirements to assure compliance with jointly developed work plans. LHI owns and shall retain all rights, title and interests, including intellectual property rights, in and to the Programs and all other Workproduct created by LHI under or in connection with this Agreement. "Workproduct" includes, without limitation, all works of original authorship (e.g. software, photographs, drawings, images, text, sound, multimedia), ideas, inventions, data and trademarks. LHI retains exclusive rights to the Program and its design, methodology, technology, and science. GREAT LAKES retains all rights to data related to its Members and their participation in the Program.

B. As permitted by law, GREAT LAKES shall provide LHI with such information as is necessary to perform its duties under this Agreement. LHI shall use such information solely for the purpose of fulfilling its duties and responsibilities hereunder and shall maintain the confidentiality of such information. Upon expiration or the earlier termination of this Agreement, any such information shall be promptly returned to GREAT LAKES. This information includes the following:

1. Electronic Provider Directory Data: Prior to Program implementation and at least yearly thereafter, GREAT LAKES shall provide LHI with a data file containing contracted physician contact information including Provider# (unique identifier for a physician at a particular location), First Name, Middle Initial Last Name, Degree, Address, City, State, Zip, Phone and Fax numbers. LHI shall use this information to prepare and fax physician progress notes regarding member enrollment and tobacco cessation status.

2. Member Eligibility Data: GREAT LAKES shall provide LHI with member eligibility data such that health plan member ID and active member status can be determined prior to participant enrollment in the Program.

C. Use of name. GREAT LAKES and LHI shall have the right to use the name, address, telephone number and other relevant information of the other for purposes of informing GREAT LAKES Members, and prospective GREAT LAKES Members of the relationship between the parties, and otherwise carrying out the terms of this Agreement. Neither Party shall use the other Party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established by GREAT LAKES or LHI, except in the manner and to the extent permitted by prior written consent of the other Party. GREAT LAKES may use LHI's "I Can Quit" logo (the "Mark") subject to GREAT LAKES' compliance with this Agreement, including the following terms and conductions.

1. During the term of this Agreement, GREAT LAKES may reproduce and use the Mark in connection with this Agreement. GREAT LAKES acknowledges and agrees that its reproduction and use of the Mark are under the sole control and supervision of LHI. GREAT LAKES' reproduction and use of the Mark, and all goodwill established thereby and/or associated therewith, shall inure exclusively to the benefit of LHI, and GREAT LAKES acquires no goodwill or other legal rights or interests in the Mark other than the right to use the Mark in connection with its activities under this Agreement.

2. GREAT LAKES shall seek prior written approval of all of its proposed uses of the Mark by, at its sole cost, submitting to LHI samples of all proposed materials depicting the form of intended use of the Mark and any words, photographs, designs or other elements intended to appear in association with the Mark. LHI shall have the right to approve or disapprove any proposed use in its sole discretion, and any failure by LHI to respond to a request shall be deemed a denial of such request. GREAT LAKES shall use the Mark solely in accordance with the approvals granted by the LHI pursuant to this Agreement.

3. All rights in the Mark not expressly granted by LHI to GREAT LAKES under this Agreement are reserved by the LHI, and GREAT LAKES may not use the Mark in any manner not expressly authorized in this Agreement. GREAT LAKES is expressly prohibited from challenging or contesting in any way the validity of the Mark, its registration with the U.S. Patent and Trademark Office (if any), or its ownership by LHI.

VII. INDEMNIFICATION

A. LHI shall defend, at its sole expense, any third party claim, demand or suit against

GREAT LAKES ("Claim") alleging and/or arising out of the following, and shall indemnify and hold GREAT LAKES harmless from and against any and all losses, liabilities, damages, fines, penalties, costs, expenses and/or fees (including reasonable attorneys' fees) awarded or assessed against GREAT LAKES in association with the Claim, or reached through a negotiated settlement of the Claim:

1. that the Program infringes a third party's patent, copyright, trademark, trade secret or other intellectual property right; and/or

2. that LHI, its employees or subcontractors was negligent or committed an intentional act that caused injury to a person or damage to property, or failed to comply with any applicable law, statute, regulation or ordinance.

B. In order to receive indemnification under this Section, GREAT LAKES must promptly notify LHI of the assertion of the Claim; allow LHI to retain sole and exclusive control over the defense and/or settlement of the Claim; and cooperate with LHI, at LHI's expense, in the defense and/or settlement of the Claim. This Section sets forth LHI's sole obligations and liability, and GREAT LAKES' exclusive remedies, in connection with the Claims described above.

VIII. INSURANCE

A. The parties shall maintain at all times policies of commercial general liability insurance with minimum coverage in amounts which are customary for similar entities and in no event less than the amounts required by applicable law, covering the parties their agents or employees, against any claims for damage arising by reason of personal injury or death occurring directly or indirectly in connection with the provision of any services , the use of any property and facilities or their respective activities, their agents or employees, in connection with the performance of this Agreement.

B. LHI will require its employees and sub-contractors to maintain professional liability insurance, where available and appropriate, according to local, state and federal law. LHI will also require minimum coverage in amounts, which are customary for similar entities and in no event less than the amounts required by applicable law.

C. LHI shall also maintain unemployment compensation and workers compensation insurance policies in accordance with the requirements of all applicable federal and state laws and regulations.

IX. DUTIES OF GREAT LAKES

In order for LHI to perform its duties under this Agreement, GREAT LAKES will:

A. Designate a contact person to whom LHI may direct all communications, correspondence, and inquiries. Such contact person will provide or arrange for the exchange of all necessary information and provide timely feedback on LHI services and Programs. The contact person shall be the Vice President of Health Services, until LHI receives written notification of a change.

B. At GREAT LAKES' discretion, designate an advisory group who will assist in Program planning, promotion, and implementation and evaluation. GREAT LAKES may determine and designate the appropriate individuals to be assigned. This group may review Program outcomes, operations and address areas for improvement.

C. Designate a senior manager to provide top management support and assist in relevant communications regarding Program activities. This manager shall be the Manager of Quality Services or such other manager as GREAT LAKES may, from time to time, designate.

D. Establish appropriate communication channels and assist in the promotion of all programs consistent with Program goals and projections that may include, for example, flyers, posters, member and physician newsletters, brochures, bulletin boards, e-mail, and meeting announcements.

X. FEES

A. LHI monthly fees will be based on information provided in Exhibit A. Fees will include all the elements outlined under LHI services (Section III). GREAT LAKES will pay for all promotional and educational brochures (other than the Program participant toolkits) that GREAT LAKES authorizes in advance, and all postage in the event GREAT LAKES requests LHI to mail brochures, satisfaction surveys or other requested items.

B. GREAT LAKES will be billed on the 1st day of each month for the prior month's Program enrollments and consultation hours. LHI shall invoice GREAT LAKES for the set-up and design fee as indicated in Exhibit A at the onset of the planning process slated to begin on May __, 2005. The Program set-up fee will be applied only once for the Program. Consultation will be provided for an initial 90 consecutive days from May ___, 2005 for no charge. LHI shall also invoice GREAT LAKES a per annum royalty fee for use of the Mark as indicated in Exhibit A. All payments will be due within 30 days of receipt of each applicable invoice. A 1.5% monthly interest fee will be charged for any invoice not fully paid within 60 days.

XI. TERMINATION OF AGREEMENT

This Agreement shall be effective as of the Effective Date and shall remain in effect for an initial period of eighteen (18) months, unless sooner terminated pursuant to the terms of this Agreement. Thereafter, this Agreement shall continue unless terminated pursuant to the terms of this Agreement.

A. Termination without Cause. Either Party may terminate this Agreement at any time with or without cause upon 90 days prior written notice to the other Party. If the Agreement has been terminated by GREAT LAKES without cause during the initial period, then all minimum fees, customization fees, license fees and Program management fees to be paid to LHI for work performed and/or the Program to the date of termination under this Agreement shall become immediately due and payable, and GREAT LAKES shall pay all such amounts to LHI within 30 days of the effective date of such termination.

B. Immediate Termination by Either Party. This Agreement may be terminated by either party as follows:

1. If either Party defaults in the observance or performance of any material obligation in this Agreement and such default is not cured or corrected within 30 days, or ten (10) days in the case of nonpayment, after written notice thereof from the aggrieved Party, the aggrieved Party may, at its option, terminate this Agreement in whole or in part by written notice to the other Party.

2. Either Party may terminate this Agreement upon written notice to the other Party if the other Party is adjudicated bankrupt or insolvent, makes an assignment for the benefit of creditors or otherwise is the subject, voluntarily or involuntarily, of any other law, rule or regulation for the relief of financial obligations and/or the protection from creditors, including, without limitation, applicable bankruptcy laws or the appointment of a receiver.

3. In the event of any termination of this Agreement in whole or in part, (a) each Party shall return or cause to be returned to the other Party all of the other Party's Confidential Information and other materials that are in its possession or control or in the possession or control of a party who may have been afforded access to the other Party's Confidential Information and other materials, except for any Confidential Information and/or other materials that are required to be retained in order to satisfy the obligations under any portion of the Agreement that is not terminated. All provisions regarding ownership, confidentiality and limitations of liability shall survive termination of this Agreement.

XII. ASSIGNMENT

No assignment by either Party pertaining to this Agreement shall be valid without the written consent of the other Party.

XIII. APPLICABLE LAW

The laws of the State of Michigan shall govern this Agreement.

XIV. AMENDMENTS

This Agreement may be amended in writing by the consent of both parties at any time.

XV. Miscellaneous

A. Entire Agreement. This Agreement and the Exhibits to this Agreement constitute the entire agreement between the parties with respect to the subject matter hereof, superseding any and all prior agreements between the parties or representations made by the parties with respect to the subject matter hereof.

B. Notices. Any notices required to be given pursuant to the terms of any provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, to the address of the other Party as follows:

TO GREAT LAKES HEALTH :
Legal Department
Great Lakes Health Plan, Inc.
17117 West Nine Mile Road - #1600
Southfield, MI 48075

TO LHI:
Michael Mulvihill
310 Miller Ave. – Ste. A
Ann Arbor, MI 48103

C. No Third Party Beneficiary. This Agreement is entered into solely for the benefit of the parties hereto and their successors in interest by virtue of an assignment, which is not prohibited hereunder and is not entered into for the benefit of any other person or entity whatsoever including, without limitation, any GREAT LAKES Member. Without limiting the generality of the foregoing, this Agreement shall not be construed as establishing any obligation, duty or practices which may exist separate and apart from this Agreement with respect to a person not a party to this Agreement.

D. Severability. If any term or provision of this Agreement shall be determined to be invalid or unenforceable by a court of competent jurisdiction for any reason, such invalidation shall not affect the validity of the whole Agreement or of any other term

or provision, but this Agreement shall be construed as if not containing the particular term or provision held to be invalid, and the rights and obligations of the parties shall be construed and enforced accordingly.

E. Waiver. The failure of any Party to strictly enforce any provision of this Agreement shall not be construed as waiver thereof or as excusing the defaulting Party from future performance. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the Party against whom such waiver is sought. One or more waivers of any covenant or condition of the Agreement by any of the parties hereto shall be construed as a waiver of any subsequent breach or of other covenants or conditions.

F. Counterparts. This Agreement and any amendments may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

G. Limitation of Liability. Except as expressly provided below, in no event shall either party be liable to the other in connection with this Agreement and/or the Program, regardless of the form of action or theory of recovery, for any: (a) indirect, special, exemplary, consequential, incidental or punitive damages, even if the party has been advised of the possibility of such damages; (b) lost profits, lost revenues, lost business expectancy, business interruption losses and/or benefit of the bargain damages; and/or (c) direct damages in an amount in excess of the amounts paid under this Agreement. Notwithstanding the foregoing, the limitations set forth above do not apply to LHI's indemnification obligations under this Agreement and/or LHI's breach of its confidentiality and privacy obligations under this Agreement.

XVI. EXECUTION OF AGREEMENT

IN WITNESS WHEREOF, GREAT LAKES and LHI have executed this Agreement in duplicate by their respective officers duly authorized to do so.

GREAT LAKES HEALTH PLAN, INC.

By:_____
(Signature)

As: General Counsel
(Title)

LEADE HEALTH, INC.

By:_____
(Signature)

As: _____
(Title)

Date:_____

Exhibit A

Leade Health's I Can Quit Tobacco Cessation Program
Services and Fees

Program Enrollment

***I Can Quit* Quit Line Health Coach Program.....$170/participant**

This fee will be cost-shared by the health plan and the Michigan Department of Community Health or MDCH as follows:

Health Plan Fee.....$100/participant
The Michigan Department of Community Health.....$70/participant

Health Plan Prenatal Participant Fee $120/participant
MDCH Prenatal Participant Cost Share Fee $60/participant

Program includes:

- Five (5) proactive phone calls from the same coach over a 12 month time period. Call schedule is as follows:
  - Initial assessment and consultation call
  - Quit date call
  - One month post quit date call
  - 6 month follow-up call
  - 12 month follow-up call

- ***I Can Quit*** tool kit for each participant including:
  - welcome letter on health plan letterhead
  - an educational workbook
  - breath mints
  - stress relieving "quit" putty
  - motivational magnet

- 24/7access to the toll-free Quit Line; calls will be responded to within 24 hours of receipt, Monday through Friday if not answered live

- Electronic satisfaction survey 3 months post enrollment. Paper surveys will be sent via postal mail to health plan members who do not provide an email address. The health plan

shall be billed postage costs for each paper satisfaction survey and business reply envelope sent via U.S. mail.

Other Program Features (no additional cost)

- Designated account manager to assist with Program set-up and maintenance. Activities included in standard account management include:
  - Communications via email and telephone to provide status reports regarding operations
  - Troubleshooting operational and/or communications issues
  - Two (2) on-site meetings per year to review outcomes and operations
- One (1) complimentary ***I Can Quit*** tool kit sample (additional kits available at cost)
- Member eligibility checks prior to enrollment
- Monthly enrollment reports (hard copy and electronic data file) providing:
  - Member name
  - Member ID
  - Date of enrollment
  - Physician name
  - Self reported co-morbidities/conditions (diabetes, asthma, CHF, CAD, hypertension, depression, depression screening outcome, pregnancy)
- Physician progress notes faxed at enrollment and 6 and 12 months post enrollment
- Integration with existing health plan disease management, case management and behavioral health programs and services.
- Two (2) outcomes report per year providing:*
  - Participant demographics (reported if N<30)
  - Enrollment trend data (reported if N<30)
  - Outcomes (N≥30) including quit rate, reduction in consumption, drop out rate, follow-up reach rate and satisfaction data
  - ROI/cost savings data (N>30)

*The first Outcomes Reports will be prepared and delivered the 8th month after the first full month of Program enrollment. Subsequent Outcomes Reports will be generated every 6 months thereafter provided at least 30 Members have enrolled in the Program during the 6 month period prior to each scheduled report compilation date.

Program Design and Set-up

Program Design and Set-up.....$6,250

This fee will be cost-shared by the health plan and the Michigan Department of Community Health as follows:

Health Plan Fee.....$3,125
The Michigan Department of Community Health.....$3,125

Program Design and Set-up fees include:

Account Management Activities

- Preparation of service agreement documents
- Management of all Program design and implementation tasks
- Maintaining communications with client including prenatal clients
- Consultation regarding Program design, goals, objectives, etc.
- Consultation regarding promotions for members, physicians and internal staff
- Completing the client profile data sheet
- Customizing participant tool kit letters with health plan logo
- Training provided to health coach staff working with health plan members including prenatal members

Data management Activities

- Loading client profile data in the Leade Health database
- Loading provider directory data into the database
- Customizing plan-specific physician progress notes
- Creating web enrollment links and links to outcomes reports
- Identifying monthly enrollment and outcomes report specifications and system programming for reporting
- Compilation of monthly enrollment and twice yearly outcomes reports
- Development and implementation of electronic data sharing processes between Leade and the health plan

iCanQuit logo (Mark) Usage Fee

Per annum royalty fee for the term of this Agreement.....$10

Consulting

Per hour fee.....$150

LHI will provide consultation, with prior approval, for the following activities on an hourly fee schedule:

- Development and submission of conference abstracts/presentations
- Report customization specific to health plan post initial implementation of Program
- Preparation and delivery of special presentations
- Grant writing
- Advisory Committee participation

- Work associated with quality and regulation requirements (HEDIS, NCQA, Clinical Practice Guidelines, quality audits, etc.)
- Development of promotions and communications beyond Program implementation
- Program enhancements beyond the scope of on-going account management

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

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

February 10, 2005

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075**	
	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 **N/A**	SHIPMENT **N/A**	**with three 1 year renewal options**
F.O.B. **N/A**	SHIPPED FROM **N/A**	
MINIMUM DELIVERY REQUIREMENTS **N/A**		

NATURE OF CHANGE (S):

Effective 1/1/2005 the attached changes are hereby incorporated into this Contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and agency request.

Total Estimated Contract Value Remains: $157,894,736.00

Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 171I0000251
PROPOSED EFFECTIVE DATE 1/1/05

Proposed Contract Change # 1
Add a new subsection in Contract Section II-C (Targeted Geographical Area for Implementation of the CHCP) to permit the contiguous county exception for voluntary enrollment in specific zip code areas of Wayne and Oakland Counties.

II-C-4. Contiguous County Exception – Wayne and Oakland Counties

3. **The Contractor may request approval to serve beneficiaries residing in a specific zip code area in a county directly contiguous to the Contractor's approved service area. The Contractor must meet all specifications outlined by DCH and receive DCH approval for the contiguous county exception. The contiguous county will be eligible for voluntary enrollments only; DCH will not auto-assign beneficiaries into the Contractor's plan in the contiguous county. This exception applies solely to Wayne and Oakland Counties.**

Proposed Contract Change # 2
Add a new bullet to Contract Section II-D 3 (Medicaid Eligible Groups Excluded From Enrollment in the CHCP) to indicate that incarcerated individuals are excluded from enrollment in the Medicaid Health Plans. Specifically, Subsection II-D-3 will be changed to read as follows:

3. Medicaid Eligible Groups Excluded From Enrollment in the CHCP:

- **Persons without full Medicaid coverage**
- **Persons with Medicaid who reside in an ICF/MR (intermediate care facilities for the mentally retarded), or a State psychiatric hospital**
- **Persons receiving long term care (custodial care) in a licensed nursing facility**
- **Persons being served under the Home & Community Based Elderly Waiver**
- **Individuals incarcerated in a correctional facility**

Proposed Contract Change # 3
Modify Contract Section II-H-9(d) to clarify Medicaid Health Plans' responsibility for monitoring Well Child/EPSDT services provided to beneficiaries identified through outreach conducted by Child and Adolescent Health Care Center and Programs. Specifically, subsection II-H-9(d) will be changed to read as follows:

The Contractor shall provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for well-child visits. Outreach contacts may be by phone, home visit, or mail. The Contractor will meet this requirement by contracting with other organizations and non-profit agencies that have a demonstrated capacity of reaching the Well Child/EPSDT target population. The Contractor will obtain information from the contracted agencies regarding members who require Well Child/EPSDT services or are overdue for Well Child/EPSDT services. The Contractor will monitor services provided to these identified members to ensure that the members receive the required services.

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

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

November 8, 2004

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075**	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** **with three 1 year renewal options**
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE (S):

Please note effective 11/1/04 the attached changes are herby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and agency contact (Cheryl Bupp) dated 11/1/04.

Total Estimated Contract Value Remains: $157,894,736.00

Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 171l0000251
PROPOSED EFFECTIVE DATE 11/1/04

Proposed Contract Change # 1
Revise section I-PP, Disclosure of Litigation, subsection 3 to make the section consistent with the litigation disclosure required under section II-W, Data Reporting. Specifically, the word "semi-annually" will be changed to "annually, such that I-PP-3 shall read as follows:

3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal or civil investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements that are prevented from disclosure by the terms of the settlement shall be annotated as such. **Annually**, during the term of the Contract, and thereafter for three years, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State.

Proposed Contract Change # 2
Revise section II-H, to provide further specification and clarification on the requirements for Persons with Special Health Care Needs. Add Persons with Special Health Care Needs to the bulleted list in II-H. And add section II-H-18 that will read as follows:

18. Persons with Special Health Care Needs

MHPs are required to do the following for members identified as persons with special health care needs:

- **Conduct an assessment in order to identify any special conditions of the enrollee that require ongoing case management services.**
- **Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.**
- **For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the enrollee.**

Proposed Contract Change # 3
Revise section II-I-5, Compliance with CMS Regulations, to include the specific provision from the Balanced Budget Act that allows Medicaid Health Plans to elect to withhold coverage for covered services based on moral or religious grounds. Specifically, the second bullet of Section II-I-5 will be revised to read as follows:

- **Provision of covered services: As required by 42CFR 438.102(a)(2), Contractors are required to provide all covered services listed in II-G and II-H of the contract. Contractors electing to withhold coverage as allowed under this provision must comply with all notification requirements.**

Proposed Contract Change # 4

Per direction from CMS, revise section II-I, Observance of Federal, State, and Local Laws, to include references to specific federal statutes with which the MHP must comply. MHP are required by contract to comply with all state and federal statutes, regulations, and administrative procedures that become effective during the terms of the contract; these specific statutes do not constitute the entire list of statutes with which the MHP must comply. Specifically, the introductory paragraph of Section II-I, Observance of Federal, State, and Local Laws, will be revised to read as follows:

The Contractor agrees that it will comply with all current state and federal statutes, regulations, and administrative procedures including Equal Employment Opportunity Provisions, Right to Inventions, Clean Air Act and Federal Water Pollution Control Act, and Byrd Anti-Lobbying Amendment. The Contractor agrees that it will comply with all current state and federal statutes, regulations, and administrative procedures that become effective during the term of this contract. Federal regulations governing contracts with risk based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434, and will govern this contract. The State is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this contract and will implement such changes pursuant to Contract Section I-Z.

Proposed Contract Change # 5

Revise subsection II-L-7, Provider Network, to accurately reflect the PCP access standard established in the Invitation to Bid (ITB). As part of the ITB process for the FY05 contract, DCH evaluated each bidder's PCP to population ratio. Bidders were only granted points for a county if the PCP to population was not more than 1 PCP for every 750 mandatory eligible persons in the county. DCH wishes to maintain this standard of access throughout the term of the contract. Therefore, the first bullet under subsection II-L-7(a) will be revised to read 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.**

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

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

November 8, 2004

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075**	
	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 **N/A**		SHIPMENT **N/A**	**with three 1 year renewal options**
F.O.B. **N/A**		SHIPPED FROM **N/A**	
MINIMUM DELIVERY REQUIREMENTS **N/A**			

NATURE OF CHANGE (S):

Please note effective 10/1/04 the attached changes are herby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and agency contact (Cheryl Bupp) dated 10/1/04.

Total Estimated Contract Value Remains: $157,894,736.00

Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 171l4001168
PROPOSED EFFECTIVE DATE 10/1/04

Proposed Contract Change # 1

Re-insert a subsection that was inadvertently deleted from the previous contract. Specifically, add a subsection 6 to section II-S (CANCELLATION) to confirm that either the State or the Contractor may cancel the contract upon 90 days written notice. Subsection II-S-6 will read as follows:

6. **Cancellation for Convenience. Either the State or the Contractor may, upon 90 days written notice, cancel the contract for the convenience of either party.**

Proposed Contract Change # 2
Incorporate the Medicaid policy revision required by PA 349 of 2004, Appropriations Act, into the Medicaid Health Plan Contract. Policy Bulletin All Provider 04-15 re-instated coverage of chiropractic, podiatric and hearing aid services to all Medicaid beneficiaries regardless of age. The law and bulletin were effective 10/1/04. Specifically, revise the first bulleted list in section II-G (SCOPE OF THE COMPREHENSIVE BENEFIT PACKAGE), to remove the words "for individuals under age 21" from the following services as follows:

- **Chiropractic services ~~for individuals under age 21~~**
- **Hearing aids ~~for individuals under age 21~~**
- **Podiatry services ~~for individuals under age 21~~**

Proposed Contract Change # 3
Implement the change in policy under which MDCH pays a maternity case rate payment for all enrollees who give birth, regardless of program. Specifically, revise the first bullet in II-AA (RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH) to remove the words "AFDC program" from the first bullet as follows:

- **Pay to the Contractor a PMPM Capitation Rate as agreed to in the Contract for each enrollee. DCH will also pay a maternity case rate payment to the Contractor for ~~AFDC program~~ enrollees who give birth while enrolled in the Contractor's plan.**

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

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

September 28, 2004

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

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075**	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 **N/A**	SHIPMENT **with three 1 year renewal options** **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

The terms and conditions of this Contract are those of ITB #071I4001168, this Contract Agreement and the vendor's quote. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: $157,894,736.00

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

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

CONTRACT NO. 071B5200007
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 559-5656 **Chris Scherer**
Great Lakes Health Plan Inc. **17117 West Nine Mile Road, Suite 1600** **Southfield, MI 48075**	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 **N/A**	SHIPMENT **N/A**	**with three 1 year renewal options**
F.O.B. **N/A**	SHIPPED FROM **N/A**	

MINIMUM DELIVERY REQUIREMENTS
N/A

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of ITB #071I4001168, this Contract Agreement and the vendor's quote. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: $157,894,736.00

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No 071I4001168. Orders for delivery may be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

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

FOR THE VENDOR:	**FOR THE STATE:**
Great Lakes Health Plan Inc. Firm Name	Signature
Authorized Agent Signature	**Sean L. Carlson** Name
Authorized Agent (Print or Type)	**Director, Acquisition Services** Title
Date	Date

ACQUISITION SERVICES
STATE OF MICHIGAN

TABLE OF CONTENTS

DEFINITION OF TERMS ..... ……ix

SECTION I

CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE 11
I-B TERM OF CONTRACT 11
I-C ISSUING OFFICE 11
I-D CONTRACT COMPLIANCE INSPECTOR 12
I-E COST LIABILITY 12
I-F CONTRACTOR RESPONSIBILITIES 12
I-G NEWS RELEASES 13
I-H DISCLOSURE 13
I-I ACCOUNTING RECORDS 13
I-J INDEMNIFICATION 14
I-K LIMITATION OF LIABILITY 15
I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS 16
I-M WARRANTIES AND REPRESENTATIONS 16
I-N TIME IS OF THE ESSENCE 16
I-O CONFIDENTIALITY OF DATA AND INFORMATION 16
I-P REMEDIES FOR BREACH OF CONFIDENTIALITY 17
I-Q CONTRACTOR'S LIABILITY INSURANCE 17
I-R NOTICE AND RIGHT TO CURE 20
I-S CANCELLATION 20
I-T RIGHTS AND OBLIGATIONS UPON CANCELLATION 22
I-U EXCUSABLE FAILURE 23
I-V ASSIGNMENT 24
I-W DELEGATION 24
I-X NON-DISCRIMINATION CLAUSE 24
I-Y WORKPLACE SAFETY AND DISCRIMINATORY HARASSMENT 24
I-Z MODIFICATION OF CONTRACT 24
I-AA NOTICES 25
I-BB ENTIRE AGREEMENT 26
I-CC NO WAIVER OF DEFAULT 26
I-DD SEVERABILITY 26
I-EE HEADINGS 26
I-FF DISCLAIMER 26
I-GG RELATIONSHIP OF THE PARTIES 27
I-HH UNFAIR LABOR PRACTICES 27
I-II SURVIVOR 27
I-JJ GOVERNING LAW 27

I-KK YEAR 2000 SOFTWARE COMPLIANCE 27
I-LL CONTRACT DISTRIBUTION.....28
I-MMSTATEWIDE CONTRACTS.....28
I-NN ELECTRONIC FUNDS TRANSFER 28
I-OO TRANSITION ASSISTANCE.....28
I-PP DISCLOSURE OF LITIGATION.....28
I-QQ REPRESENTATION IN LITIGATION.....30

SECTION II

WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT 31
1. Value Purchasing 31
2. Managed Care Direction 31
II-B OBJECTIVES 32
1. General Objectives 32
2. Specific Objectives 32
3. Objectives for Contractor Accountability 32
II-C TARGETED GEOGRAPHICAL AREA FOR IMPLEMENTATION OF THE CHCP 33
1. Regions 33
2. Multiple Region Service Areas 34
3. Contiguous County Service Areas 34
II-D MEDICAID ELIGIBILITY AND CHCP ENROLLMENT 34
1. Medicaid Eligible Groups Who Must Enroll in the CHCP: 34
2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP: 34
3. Medicaid Eligible Groups Excluded From Enrollment in the CHCP: 34
II-E ELIGIBILITY DETERMINATION 35
II-F ENROLLMENT IN THE CHCP 35
1. Enrollment Services 35
2. Initial Enrollment 35
3. Enrollment Lock-in and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions 36
4. Rural Area Exception 36
5. Preferred Option Program 36
6. Enrollment Date 37
7. Newborn Enrollment 37
8. Automatic Re-enrollment 37
9. Enrollment Errors by the Department 37
10. Enrollees Who Move Out of the Contractor's Service Area 37
11. Disenrollment Requests Initiated by the Contractor 38
12. Medical Exception 38
13. Disenrollment for Cause Initiated by the Enrollee 38
II-G SCOPE OF COMPREHENSIVE BENEFIT PACKAGE 39
1. Services Included 39
2. Enhanced Services 39
3. Services Covered Outside of the Contract 40
4. Services Prohibited or Excluded Under Medicaid: 40
II-H SPECIAL COVERAGE PROVISIONS 40
1. Emergency Services 41
2. Out-of-Network Services 42
3. Family Planning Services 42
4. Maternal and Infant Support Services 42
5. Federally Qualified Health Centers (FQHCs) 43
6. Co-payments 43
7. Abortions 44
8. Pharmacy 44

9. Well Child Care/Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program 44
10. Immunizations 46
11. Transportation 46
12. Transplant Services 46
13. Communicable Disease Services 46
14. Restorative Health Services 46
15. Child and Adolescent Health Centers and Programs 47
16. Hospice Services 47
17. Twenty (20) Visit Mental Health Outpatient Benefit 47
II-I OBSERVANCE OF FEDERAL, STATE, AND LOCAL LAWS 47
1. Special Waiver Provisions for CHCP 48
2. Fiscal Soundness of the Risk-Based Contractor 48
3. Prohibited Affiliations with Individuals De-barred by Federal Agencies 48
4. Public Health Reporting 48
5. Compliance with CMS Regulation 48
6. Compliance with HIPAA Regulation 49
7. Advanced Directives Compliance 49
8. Medicaid Policy 49
II-J CONFIDENTIALITY 49
II-K CRITERIA FOR CONTRACTORS 49
1. Administrative and Organizational Criteria 49
2. Financial Criteria 50
3. Provider Network and Health Service Delivery Criteria 50
II-L CONTRACTOR ORGANIZATIONAL STRUCTURE, ADMINISTRATIVE SERVICES, FINANCIAL REQUIREMENTS AND PROVIDER NETWORKS 50
1. Organizational Structure 50
2. Administrative Personnel 51
3. Administrative Requirements 53
4. Program Integrity 53
5. Management Information Systems 54
6. Governing Body 54
7. Provider Network 55
(a) General 55
(b) Inclusion 56
(c) Coordination of Care with Public and Community Providers and Organizations 56
(d) Coordination of Care with Local Behavioral Health and Developmental Disability Providers 57
(e) Network Changes 57
(f) Provider Contracts 57
(g) Disclosure of Physician Incentive Plan 58
(h) Provider Credentialing 58
(i) Primary Care Provider (PCP) Standards 58
II-M PAYMENT TO PROVIDERS 60
1. Electronic Billing Capacity 60
2. Payment Resolution Process 60
3. Arbitration 60
4. Post-payment Review 61
5. Total Payment 61
6. Enrollee Liability for Payment 61

7. Hospital Payments 61
II-N PROVIDER SERVICES (In-Network and Out-of-Network) 61
II-O QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 62
1. Quality Assessment and Performance Improvement Program (QAPI) 62
2. Annual Effectiveness Review 63
3. Annual Performance Improvement Projects 63
4. Performance Monitoring 63
5. External Quality Review (EQR) 63
6. Consumer Survey 64
II-P UTILIZATION MANAGEMENT 64
II-Q THIRD PARTY RESOURCE REQUIREMENTS 64
II-R MARKETING 65
1. Allowed Marketing Locations 65
2. Prohibited Marketing Locations 65
3. Marketing Materials 65
II-S ENROLLEE SERVICES 66
1. General 66
2. Enrollee Education 67
3. Member Handbook/Provider Directory 67
4. Protection of Enrollees against Liability for Payment and Balanced Billing 69
II-T GRIEVANCE/APPEAL PROCEDURES 69
1. Contractor Grievance/Appeal Procedure Requirements 69
2. Notice to Enrollees of Grievance Procedure 69
3. Notice to Enrollees of Appeal Procedure 69
4. State Medicaid Appeal Process 70
5. Expedited Appeal Process 70
II-U CONTRACTOR ON-SITE REVIEWS 71
II-V CONTRACT REMEDIES AND SANCTIONS 71
II-W DATA REPORTING 71
1. HEDIS® Submission 72
2. Encounter Data Submission 72
3. Financial and Claims Reporting 72
4. Semi-annual Grievance and Appeal Report 73
II-X RELEASE OF REPORT DATA 73
II-Y MEDICAL RECORDS 73
1. Medical Record Maintenance 73
2. Medical Record Confidentiality/Access 73
II-Z PAYMENT PROVISIONS 73
1. Contractor Performance Bonus 74
II-AA RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH 74
II-BB MEMORANDUM OF AGREEMENT WITH DETROIT HEALTH AUTHORITY (DWCHA) 75

LIST OF APPENDICES

Appendix 1: Rural Exception Counties 68

Appendix 2: Financial Monitoring Standards 69

Appendix 3: Health Plan Reporting Schedule 70

Appendix 4: Performance Monitoring Standards 71

Appendix 5: Performance Bonus 73

LIST OF ATTACHMENTS

Attachment A: Per Member Per Month Capitated Rates by Region by County

Attachment B: Approved Service Area by Region by County

DEFINITION OF TERMS

TERMS	DEFINITIONS
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
ACIP	Advisory Committee on Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
Administrative Law Judge	A person designated by DCH to conduct the Administrative Hearing in an impartial or unbiased manner.
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated.
Appeal	As defined in 42 CFR 438.400(3)(b). A request for review of a Contractor's decision that results in any of the following actions: • The denial or limited authorization of a requested service, including the type or level of service; • The reduction, suspension, or termination of a previously authorized service; • The denial, in whole or in part, of payment for a properly authorized and covered service; • The failure to provide services in a timely manner, as defined by the State; • The failure of a Contractor to act within the established timeframes for grievance and appeal disposition; • For a resident of a rural area with only one Medicaid Health Plan, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
Balanced Budget Act	The Balanced Budget Act (BBA) of 1997 (Public law 105-33). The BBA establishes the rules and regulations for the 1915 (b) waiver under which the CHCP is administered.
Beneficiary	Any person determined eligible for the Medical Assistance Program as defined below.
Blanket Purchase Order	Alternative term for "Contract" used in the State's computer system (Michigan Automated Information Network) MAIN.
Business Day	Monday through Friday except those days identified by the State as holidays.
CAC	Clinical Advisory Committee appointed by the DCH
Capitation Rate	A fixed per person monthly rate payable to the Contractor by the DCH for provision of all Covered Services defined within this Contract.

CFR	Code of Federal Regulations
CHCP	Comprehensive Health Care Program. Capitated health care services for Medicaid Beneficiaries in specified counties provided by Medicaid Health Plans that contract with the State.
Clean Claim	Clean Claim means that as defined in MCL 400.111i
CMHSP	Community Mental Health Services Program
CMS	Centers for Medicare and Medicaid Services
Contract	A binding agreement entered into by the State of Michigan and the Contractor; see also "Blanket Purchase Order."
Contractor	The successful bidder who is awarded a Contract. In this ITB, the terms Contractor, HMO, Contractor's plan, Medicaid Health Plan, MHP and Health Plan are used interchangeably.
Covered Services	All services provided under Medicaid, as defined in ITB Section II-G(1)-(2) that the Contractor has agreed to provide or arrange to be provided.
CSHCS	Children's Special Health Care Services
DCH OR MDCH	The Department of Community Health or the Michigan Department of Community Health and its designated agents.
DCH Administrative Hearing	Also called a fair hearing, an impartial review by DCH of a decision made by the Contractor that the Enrollee believes is inappropriate. An Administrative Law Judge conducts the Administrative Hearing.
Department	The Michigan Department of Community Health and its designated agents.
DMB	The Michigan Department of Management and Budget
Emergency Medical Care/Services (EMC)	Those services necessary to treat an emergency medical condition. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
Enrollee	Any Medicaid Beneficiary who is currently enrolled in Medicaid managed care in a given Medicaid Health Plan.
Enrollment Capacity	The number of persons that the Contractor can serve through its provider network under a Contract with the State. Enrollment Capacity is determined by a Contractor based upon its provider network organizational capacity and available risk-based capital.
Enrollment Service	An entity contracted by the DMB to contact and educate general Medicaid and Children's Special Health Care Services Beneficiaries about managed care and to enroll, disenroll, and change enrollment(s) for these Beneficiaries.

Expedited Appeal	An appeal conducted when the Contractor determines (based on the Enrollee request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.
Expedited Authorization Decision	An authorization decision required to be expedited due to a request by the provider or determination by the Contractor that following the standard timeframe could seriously jeopardize the Enrollee's life or health.
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
FIA	Family Independence Agency
FFS	Fee-for-service. A reimbursement methodology that provides a payment amount for each individual service delivered.
FQHC	Federal Qualified Health Center
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).
Grievance	Grievance means an expression of dissatisfaction about any matter other than an action subject to appeal. (42 CFR 438.400)
HEDIS	Health Employer Data and Information Set; the result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a group of 60 performance measures that gives employers some objective information with which to evaluate health plans and hold them accountable.
HMO	An entity that has received and maintains a State certificate of authority to operate as a Health Maintenance Organization as defined in MCL 500.3501.
ITB	Invitation to Bid - A solicitation that contains specifications designed to meet a well-defined State need. It informs the bidder of requirements for submitting a bid based on the ITB specifications. Contract award is based on an evaluation of the degree to which the bidder meets those specifications
Long Term Care Facility	Any facility licensed and certified by the Michigan Department of Community Health, in accordance with the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, to provide inpatient nursing care services.
Marketing	Marketing means any communication, from a Contractor directed to a Medicaid Beneficiary who is not enrolled in the Contractor's plan, that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another health plan's Medicaid product.
Medicaid/Medical Assistance Program	A federal/state program authorized by the Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and section 105 of 1939 PA 280, as amended, MCL 400.1 – 400.122; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.

Medicaid Health Plan	Managed care organizations that provide or arrange for the delivery of comprehensive health care services to Medicaid enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as a Health Maintenance Organization (HMO). See also Contractor.
MSA	Medical Services Administration, the agency within the Department of Community Health responsible for the administration of the Medicaid Program.
PCP	Primary Care Provider. Those providers within the MHPs who are designated as responsible for providing or arranging health care for specified Enrollees of the Contractor.
Persons with Special Health Care Needs	Enrollees who have lost eligibility for the Children's Special Health Care Services (CSHCS) program due to the program's age requirements.
PIHP	Prepaid Inpatient Health Plan
PMPM	Per Member Per Month
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
Provider	Provider means a health facility or a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211.
QIC	Quality Improvement Committee
Rural	Rural is defined as any county not designated as metropolitan or outlying metropolitan by the 2000 U. S. Census.
State	The State of Michigan
Subcontractor	A subcontractor is any person or entity that performs a required, ongoing function of the Contractor under this Contract. A health care provider included in the network of the Contractor is not considered a subcontractor for purposes of this Contract unless otherwise specifically noted in this Contract. Contracts for one-time only functions or service contracts, such as maintenance or insurance protection, are not intended to be covered by this section.
Successful Bidder	The bidder(s) awarded a Contract as a result of a solicitation.
VFC	Vaccines for Children program. A federal program which makes vaccine available free to immunize children age 18 and under who are Medicaid eligible.
Well Child Visits/EPSDT	Early and periodic screening, diagnosis, and treatment program. A child health program of prevention and treatment intended to ensure availability and accessibility of primary, preventive, and other necessary health care resources and to help Medicaid children and their families to effectively use these resources.

SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE

The purpose of this Contract is to obtain the services of one or more Contractors to provide Comprehensive Health Care Program (CHCP) Services for Medicaid beneficiaries in the service area within the State of Michigan, as described in Attachment B.

This will be a unit price (Per Member Per Month Capitated Rate) Contract, see Attachment A. Because beneficiaries must have a choice among Contractors, the State cannot guarantee an exact number of enrollees to any Contractor. The term of the Contract shall be effective October 1, 2004 and continue until October 1, 2006. The Contract may be extended for no more than three (3) one (1) year extensions after September 30, 2006.

I-B TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by any bidder prior to signing of a Contract by all parties. The Contract covers the period from October 1, 2004 through September 30, 2006. The Contract may be extended for no more than three (3) one (1) year extensions after September 30, 2006, and are subject to price adjustments. The State fiscal year is October lst through September 30th. The Contractor should realize that payments in any given fiscal year are contingent upon State and Federal appropriations and approval by the Michigan State Administrative Board.

I-C ISSUING OFFICE

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Acquisition Services, hereafter known as Acquisition Services, for the State of Michigan, Michigan Department of Community Health (MDCH), Medical Services Administration (MSA). Where actions are a combination of those of Acquisition Services and MDCH, MSA the authority will be known as the State.

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

Irene Pena, CPPB
DMB, Acquisition Services
2nd Floor, Mason Building
P.O. Box 30026
Lansing, MI 48909
Penai1@michigan.gov and (517) 241-1647

I-D CONTRACT COMPLIANCE INSPECTOR

Upon receipt at Acquisition Services of the properly executed Contract Agreement, it is anticipated that the Director of Acquisition Services will direct that the person named below or any other person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of any Contract resulting from this Request implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by Acquisition Services. The Contract Compliance Inspector for this project is:

Cheryl Bupp, Acting Director
Department of Community Health
Managed Care Plan Division
P.O. Box 30479
Lansing, Michigan 48909-7979
BuppC@Michigan.gov and 517-241-7933

I-E COST LIABILITY

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

I-F CONTRACTOR RESPONSIBILITIES

The Contractor will be responsible for the performance of all the obligations under this Contract, whether the obligations are performed by the Contractor or a subcontractor. 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 provisions of the Contract.

A subcontractor is any person or entity that performs a required, ongoing function of the Contractor under this Contract. A health care provider included in the network of the Contractor is not considered a subcontractor for purposes of this Contract unless otherwise specifically noted in this Contract. Contracts for one-time only functions or service contracts, such as maintenance 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 not specified in the Contractor's response, the State must be provided with a written request at least 21 days prior to the use of such subcontractor. Use of a subcontractor not approved by the State may be cause for termination of the Contract.

In accordance with 42 CFR 434.6(b), all subcontracts 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 must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All 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, the proposal must include: (1) the identification of the functions to be performed by the subcontractor, and (2) the subcontractor'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, 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, the qualifications of the subcontractor for guaranteeing performance, and any other data that may be required by the State. All subcontracts 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.

I-G NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.

I-H DISCLOSURE

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

I-I ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Auditor General at any time during the Contract period and any extension thereof, and for six (6) years from the expiration date and final payment on the Contract or extension thereof.

I-J INDEMNIFICATION

A. General Indemnification

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections, commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

1. Any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the product provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract;

2. Any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;

3. Any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or related to occurrences that the Contractor is required to insure against as provided for in this Contract;

4. Any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable; provided, however, that this indemnification obligation shall not apply to the extent, if any, that such death, bodily injury or property damage is caused solely by the negligence or reckless or intentional wrongful conduct of the State;

5. Any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

B. Patent/Copyright Infringement Indemnification

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its employees and agents from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software,

commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software, commodity or service infringes any United States or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor shall at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

C. Indemnification Obligation Not Limited

In any and all claims against the State of Michigan, or any of its agents or employees, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

D. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and affect not withstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions, which occurred prior to termination.

E. Indemnification Exclusion

The Contractor is not required to indemnify the State of Michigan for services provided by health care providers mandated under federal statute or State policy, unless the health care provider is a voluntary contractual member of the Contractor's provider network. Local agreements with Community Mental Health Services Program (CMHSP) and/or Prepaid Inpatient Health Plan (PIHP) do not constitute network provider contracts.

I-K LIMITATION OF LIABILITY

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

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

I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS

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

I-M WARRANTIES AND REPRESENTATIONS

The Contractor warrants and represents, without limitation, that the Contractor shall comply with the following:

1. Perform all services in accordance with high professional standards in the industry;

2. Use adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services;

3. Use its best efforts to use efficiently any resources or services necessary to provide the services that are separately chargeable to the State;

4. Use its best efforts to perform the services in the most cost effective manner consistent with the required level of quality and performance;

5. Perform the services in a manner that does not infringe the proprietary rights of any third party;

6. Perform the services in a manner that complies with all applicable laws and regulations;

7. Duly authorize the execution, delivery and performance of the Contract;

8. Not provide any gifts, payments or other inducements to any officer, employee or agent of the State;

I-N TIME IS OF THE ESSENCE

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

I-O CONFIDENTIALITY OF DATA AND INFORMATION

1. All financial, statistical, personnel, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.

2. The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State. Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

3. The use or disclosure of information regarding Enrollees obtained in connection with the performance of this Contract shall be restricted to purposes directly related to the administration of services required under the Contract, unless otherwise required by law.

I-P REMEDIES FOR BREACH OF CONFIDENTIALITY

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

I-Q CONTRACTOR'S LIABILITY INSURANCE

The Contractor is required to provide proof of the minimum levels of insurance coverage as indicated below. The purpose of this coverage shall be to protect the State from claims which may arise out of or result from the Contractor's performance of services under the

terms of this Contract, whether such services are performed by the Contractor, or by any subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain pursuant to this Contract. The Contractor also agrees to provide evidence that all applicable insurance policies contain a waiver of subrogation by the insurance company.

All insurance coverages provided relative to this Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The Insurance shall be written for not less than any minimum coverage herein specified or required by law, whichever is greater. All deductible amounts for any of the required policies are subject to approval by the State.

The State reserves the right to reject insurance written by an insurer the State deems unacceptable.

BEFORE THE CONTRACT IS SIGNED BY BOTH PARTIES OR BEFORE THE PURCHASE ORDER IS ISSUED BY THE STATE, THE CONTRACTOR MUST FURNISH TO THE DIRECTOR OF Acquisition Services, CERTIFICATE(S) OF INSURANCE VERIFYING INSURANCE COVERAGE. THE CERTIFICATE MUST BE ON THE STANDARD "ACCORD" FORM. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. All such Certificate(s) are to be prepared and submitted by the Insurance Provider and not by the Contractor. All such Certificate(s) shall contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without THIRTY (30) days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Acquisition Services, Department of Management and Budget. Such NOTICE must include the CONTRACT NUMBER affected and be mailed to: Director, Acquisition Services, Department of Management and Budget, P.O. Box 30026, Lansing, Michigan 48909.

The Contractor is required to provide the type and amount of insurance checked (☑) below:

☑ 1. Commercial General Liability with the following minimum coverages:

$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit
$500,000 Fire Damage Limit (any one fire)

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as ADDITIONAL INSUREDS on the Commercial General Liability policy.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor‘s business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as ADDITIONAL INSUREDS on the vehicle liability policy.

☑ **3.** Worker’s disability compensation, disability benefit or other similar employee benefit act with minimum statutory limits. NOTE: (1) If coverage is provided by a State fund or if Contractor has qualified as a self-insurer, separate certification must be furnished that coverage is in the state fund or that Contractor has approval to be a self-insurer; (2) Any citing of a policy of insurance must include a listing of the States where that policy’s coverage is applicable; and (3) Any policy of insurance must contain a provision or endorsement providing that the insurers’ rights of subrogation are waived. This provision shall not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☐ 4. For contracts providing temporary staff personnel to the State, the Contractor shall provide an Alternate Employer Endorsement with minimum coverage of $1,000,000.

☑ 5. Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ 6. Professional Liability Insurance (Errors and Omissions coverage) that includes coverage of the contractor's peer review and case management activities with the following minimum coverage

- ☑ $1,000,000 each occurrence and $3,000,000 annual aggregate
- ☐ $3,000,000 each occurrence and $5,000,000 annual aggregate
- ☐ $5,000,000 each occurrence and $10,000,000 annual aggregate

☐ 7. Medical Professional Liability, minimum coverage *(Medical Professional Liability Insurance is required anytime the State contracts with a medical professional. If a single practitioner will be providing services on site at an agency facility, CGL is NOT required.)*

- ☐ $100,000 each occurrence and $300,000 annual aggregate *(for single practitioner)*
- ☐ $200,000 each occurrence and $600,000 annual aggregate *(for single practitioner)*

☐ $1,000,000 each occurrence and $5,000,000 annual aggregate *(for group practice)*

☑ **8.** The Contractor shall also require that each of its subcontractors maintain insurance coverage as specified above, except for subparagraph (6), or have the subcontractors provide coverage for each subcontractor's liability and employees. The Contractor must provide proof, upon request of the DCH, of its Provider's medical professional liability insurance in amounts consistent with the community accepted standards for similar professionals. The provision of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its subcontractors herein.

I-R NOTICE AND RIGHT TO CURE

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage or destruction of any real or tangible personal property.

I-S CANCELLATION

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

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

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

   All excess reprocurement costs and damages shall not be considered by the parties to be consequential, indirect, or incidental, and shall not be excluded by any other terms otherwise included in the Contract.

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

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a cancellation for convenience, effective as of the same date, and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2. Cancellation For Convenience By the State. The State may cancel this Contract for it convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not limited to (a) the State no longer needs the services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 90 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.

   In the event that a Contract is canceled, the Contractor will cooperate with the State to implement a transition plan for Enrollees. The Contractor will be paid for Covered Services provided during the transition period in accordance with the Capitation Rates in effect between the Contractor and the State at the time of cancellation. Contractors will be provided notice before the termination of any Contract.

3. Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.

4. Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to

   any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal

offense which in the sole discretion of the State, reflects upon the Contractor's business integrity, the State may immediately cancel this Contract without further liability to the State.

5. Approvals Rescinded. The State may cancel this Contract without further liability or penalty in the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to the Michigan Constitution of 1963, Article 11, Section 5, and Civil Service Rules, Chapter 7. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in such written notice.

I-T RIGHTS AND OBLIGATIONS UPON CANCELLATION

1. If the Contract is canceled by the State for any reason, the Contractor shall, (a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Compliance Inspector or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.

2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date. All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs, or expenses incurred with respect to Services not actually performed for the State.

3. If any such cancellation by the State is for cause, the State shall have the right to set-off against any amounts due the Contractor, the amount of any damages for which the Contractor is liable to the State under this Contract or pursuant to law and equity.

4. Upon a good faith cancellation, the State shall have the right to assume, at its option, any and all subcontracts and agreements for services and materials provided under this Contract, and may further pursue completion of the Work Product under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

I-U EXCUSABLE FAILURE

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

2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor. The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure

   condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I-V ASSIGNMENT

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

I-W DELEGATION

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

I-X NON-DISCRIMINATION CLAUSE

In the performance of any Contract or purchase order resulting herefrom, the bidder agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The bidder further agrees that every subcontract entered into for the performance of any Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot-Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2201, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.

I-Y WORKPLACE SAFETY AND DISCRIMINATORY HARASSMENT

In performing services for the State pursuant to this Contract, the Contractor shall comply with Department of Civil Service Rules 2-20 regarding Workplace Safety and 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor shall comply with Civil Service Regulations governing workplace safety and discriminatory harassment and any applicable state agency rules on these matters that the agency provides to the Contractor. Department of Civil Service Rules and Regulations can be found on the Department of Civil Service website at www.michigan.gov/mdcs.

I-Z MODIFICATION OF CONTRACT

The Director of Acquisition Services reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary.

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

The State reserves the right to negotiate expansion of the services outlined within this Contract to accommodate the related service needs of additional selected State agencies, or of additional entities within DCH.

Such expansion shall be limited to those situations approved and negotiated by the Acquisition Services at the request of DCH or another State agency. The Contractor shall be obliged to expeditiously evaluate and respond to specified needs submitted by the Acquisition Services with a proposal outlining requested services. All pricing for expanded services shall be shown to be consistent with the unit pricing of the original Contract.

In the event that a Contract expansion proposal is accepted by the State, the Acquisition Services shall issue a Contract change notice to the Contract as notice to the Contractor to provide the work specified. Compensation is not allowed the Contractor until such time as a Contract change notice is issued.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. The Contractor shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, the Contractor shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment. The price adjustment shall be based on a good faith determination and calculation by the Contractor of the additional cost to the Contractor in implementing the change request less any savings realized by the Contractor as a result of implementing the change request. The Contractor's proposal shall describe in reasonable detail the basis for the Contractor's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.

2. If the State accepts the Contractor's proposal, it will issue a change notice and the Contractor will implement the change request described therein. The Contractor will not implement any change request until a change notice has been issued validly. The Contractor shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.

3. If the State does not accept the Contractor's proposal, the State may:
   a. Withdraw its change request; or
   b. Modify its change request, in which case the procedures set forth above will apply to the modified change request.

I-AA NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is

sent by another means specified in this section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

I-BB ENTIRE AGREEMENT

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

The following documents constitute the complete and exclusive statement of the agreement between the parties as it relates to this transaction. In the event of any conflict among the documents making up the Contract, the following order of precedence shall apply (in descending order of precedence):

A. The Contract resulting from ITB and any Addenda thereto
B. State's ITB and any Addenda thereto
C. Contractor's proposal to the State's ITB and Addenda
D. Policy manuals of the Medical Assistance Program and subsequent publications

The Contractor acknowledges that in the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the State and those indicated by the Contractor, those of the State take precedence.

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

I-CC NO WAIVER OF DEFAULT

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

I-DD SEVERABILITY

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

I-EE HEADINGS

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-FF DISCLAIMER

All statistical and fiscal information contained within the Contract and its attachments, and any amendments and modifications thereto, reflect information available to DCH at

the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages.

I-GG RELATIONSHIP OF THE PARTIES

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

I-HH UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, specifically MCL 423.323, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to section 2 of the Act. This information is compiled by the United States National Labor Relations Board.

Pursuant to section 4 of 1980 Public Act 278, specifically MCL 423.323, a Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. The State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-II SURVIVOR

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

I-JJ GOVERNING LAW

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

I-KK YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor's

business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors, or untimely performance resulting therefrom.

I-LL CONTRACT DISTRIBUTION

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

I-MM STATEWIDE CONTRACTS

If the contract is for the use of more than one agency and if the goods or services provided under the contract do not meet the form, function, and utility required by an agency, that agency may, subject to state purchasing policies, procure the goods or services from another source.

I-NN ELECTRONIC FUNDS TRANSFER

Electronic transfer of funds is available to State contractors. Vendors are encouraged to register with the State of Michigan Office of Financial Management so the State can make payments related to this Contract electronically at www.cpexpress.state.mi.us.

I-OO TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to **one (1) year** after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.

I-PP DISCLOSURE OF LITIGATION

1. The Contractor shall notify the State in its bid proposal, if it, or any of its subcontractors, or their officers, directors, or key personnel under this Contract, have ever been convicted of a felony, or any crime involving moral turpitude, including,

but not limited to fraud, misappropriation or deception. Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding which may have arisen or may arise involving the Contractor or any of the Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract and three years thereafter.

2. The Contractor shall notify the State in its bid proposal, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments that may have arisen against it or its subcontractors during the five years proceeding its bid proposal, or which may occur during the term of this Contract or three years thereafter, which involve (1) products or services similar to those provided to the State under this Contract and which either involve a claim in excess of $250,000 or which otherwise may affect the viability or financial stability of the Contractor , or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor, in any an amount less than $250,000 shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.

3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal or civil investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements that are prevented from disclosure by the terms of the settlement shall be annotated as such. Semi-annually, during the term of the Contract, and thereafter for three years, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State.

4. Assurances - In the event that such investigation, litigation, arbitration or other proceedings disclosed to the State pursuant to this Section, or of which the State otherwise becomes aware, during the term of this Contract, causes the State to be reasonably concerned about:

   a) the ability of the Contractor or its subcontractor to continue to perform this Contract in accordance with its terms and conditions, or

   b) whether the Contractor or its subcontractor in performing services is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration or other proceedings, which conduct would constitute a breach of this Contract or violation of Michigan or Federal law, regulation or public policy, then

   The Contractor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that: (a) the Contractor or its subcontractors hereunder will be able to continue to perform this Contract in accordance with its terms and conditions, (b) the Contractor or its subcontractors will not engage in

conduct in performing services under this Contract which is similar in nature to the conduct alleged in any such litigation, arbitration or other proceedings.

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

I-QQ REPRESENTATION IN LITIGATION

The State, its departments, and its agents shall not be responsible for representing or defending the Contractor, Contractor's personnel, or any other employee, agent or subcontractor of the Contractor, named as a defendant in any lawsuit or in connection with any tort claim.

The State and the Contractor agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or persons not a party to the Contract.

The provisions of this section shall survive the expiration or termination of the Contract.

SECTION II
WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

1. Value Purchasing

DCH merges policy, programs, and resources to enable the State to continue to be an effective purchaser of health care services for the Medicaid population. As the single State agency responsible for health policy and purchasing of health care services using State appropriated and federal matching funds, DCH employs fiscally prudent purchasing while ensuring quality and access. DCH continues to focus on "value purchasing." Value purchasing involves aligning financing incentives to stimulate appropriate changes in the health delivery system that will:

- Require organization and accountability for the full range of benefits,
- Encourage creativity to provide the widest range of services with limited resources;
- Maintain and improve access to and quality of care;
- Continue to make advancements in cost efficiency; and
- Monitor improvements in the health status of the community to ensure that Contractor's performance supports continued improvements.

2. Managed Care Direction

Under the Comprehensive Health Care Program (CHCP), the State selectively awards risk-based contracts to Contractors with demonstrated capability and capacity for managing comprehensive care through a performance contract. The Contractors are partners with the State in providing fiscally prudent services to improve and maintain the health status of Medicaid beneficiaries. Michigan continues to focus on quality of care, accessibility, and cost-effectiveness.

Michigan's financial status dictates that Michigan must control the Medicaid budget. The recent economic downturn in Michigan has led to a decline in available State revenues. At the same time, Medicaid expenditures have grown rapidly due to several factors such as increases in the number of persons eligible for assistance; increases in the utilization of services; and inflation in service costs. The Medicaid budget is currently 25% of the State budget. The Medicaid budget must be controlled but, at the same time, access to quality health care for the Medicaid population must be preserved.

The financial circumstances have required Michigan to take three approaches to control costs: re-define eligibility, reduce benefits, and stimulate more efficiency in the health delivery system through managed care. DCH strives to provide the widest range of services to as many needy individuals as is fiscally prudent. Therefore, DCH prefers to utilize the efficiency approach because other important health care goals can be achieved at the same time the budget is controlled.

There are two categories of specialized services that are available outside of the CHCP. These are behavioral health services and services for persons with developmental disabilities. These specialized services are clearly defined as beyond the scope of benefits that are included in the CHCP. Any Contractor contracting with the State as a capitated managed care provider will be responsible for coordinating access to these specialized services with those providers designated by the State to provide them. The criteria for contracted Medicaid Health Plans (MHPs) include the implementation of local agreements with the behavioral health and developmental disability providers who are under contract with DCH.

II-B OBJECTIVES

1. General Objectives

   The general Contract objectives of the State are:

   - Access to primary and preventive care;
   - Establish a "medical home" and the coordination of all necessary health care services;
   - Provision of high quality medical care that provides continuity of care and is appropriate for the individual; and
   - Operation of a health care delivery system that enables Michigan to control and predict the cost of medical care for the Medicaid population.

2. Specific Objectives

   When providing services under the CHCP, the Contractor must take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population in the CHCP. The Contractor must also participate in the collaborative efforts of the State, the communities, and the private sector to operate a managed care system that meets the special needs of these enrollees.

   It is recognized that special needs will vary by individual and by county or region. Contractors must have an underlying organizational capacity to address the special needs of their enrollees, such as: responding to requests for assignment of specialists as Primary Care Providers (PCP), assisting in coordinating with other support services, and generally responding and anticipating needs of enrollees with special or culturally-diverse needs. Under their covered service responsibilities, Contractors are expected to provide early prevention and intervention services for enrollees with specific needs, as well as all other enrollees.

   * As an example, while support services for persons with developmental disabilities may be outside of the direct service responsibility of the Contractor, the Contractor does have the responsibility to assist in coordinating arrangements to ensure these persons receive necessary support services. This coordination must be consistent with the person-centered planning principles established within the Michigan's Mental Health Code.

   * Another example is enrollees who have chronic illnesses such as diabetes or end-stage renal disease. In these instances, it may be more appropriate to assign a specialist within the Contractor's network as the PCP. When a Contractor designates a physician specialist as the PCP, that PCP-specialist will be responsible for coordinating all continuing medical care for the assigned enrollee.

3. Objectives for Contractor Accountability

   Contractor accountability must be established in order to ensure that the State's objectives for managed care are met. Highlights of the State's objectives for contractor accountability include the following:

   - Ensuring that all covered services are available and accessible to enrollees with reasonable promptness and in a manner, which ensures continuity.
   - Delivering health care services in a manner that focuses on health promotion and disease prevention and features disease management strategies.
   - Demonstrating the Contractor's provider network and financial capacity to adequately serve the Contractor's expected enrollment of enrollees.
   - Meeting or exceeding the goals set forth for the Contractors in the DCH's Quality Strategy.

- Providing access to appropriate providers, including qualified specialists for all medically necessary services, behavioral health, and developmental disabilities services.
- Providing assurances that it will not deny enrollment to, expel, or refuse to re-enroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of such assurances at the time of enrollment.
- Paying providers in a timely manner for all covered services.
- Providing procedures to ensure program integrity through the detection and prevention of fraud and abuse and cooperate with DCH and the Department of Attorney General as necessary.
- Reporting encounter data and aggregate data including data on inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by the Department.
- Providing assurances for the Contractor's solvency and guaranteeing that enrollees and the State will not be liable for debts of the Contractor.
- Meeting all standards and requirements contained in this Contract, and complying with all applicable federal and state laws, administrative rules, and policies promulgated by DCH.
- Cooperating with the State and/or CMS in all matters related to fulfilling Contract requirements and obligations.

II-C TARGETED GEOGRAPHICAL AREA FOR IMPLEMENTATION OF THE CHCP

1. Regions

The State will divide the delivery of covered services into ten regions.

Contractors must establish a network of providers that guarantees access to required services for the entire region or the applicable counties in the region the Contractor proposes to service. The Contractor must provide a complete description of the provider network.

The counties included in the specific regions are as follows:

Region 1: Wayne

Region 2: Hillsdale, Jackson, Lenawee, Livingston, Monroe, and Washtenaw

Region 3: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren

Region 4: Allegan, Antrim, Benzie, Charlevoix, Cheboygan, Emmet, Grand Traverse, Ionia, Kalkaska, Kent, Lake, Leelanau Manistee, Mason, Mecosta, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa, and Wexford

Region 5: Clinton, Eaton, Ingham

Region 6: Genesee, Lapeer, Shiawassee

Region 7: Alcona, Alpena, Arenac, Bay, Clare, Crawford, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Tuscola

Region 8: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

Region 9: Macomb and St. Clair

Region 10: Oakland

2. Multiple Region Service Areas

   Although Contractors may propose to contract for services in more than one of the above-described regions, the Contractor agrees to tailor the services to each individual region in terms of the provider network, enrollment capacity, and any special health issues applicable to the region. DCH may determine Contractors to be qualified in one region but not in another.

   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 need for additional capacity in the counties proposed under the expansion request. Request should be submitted using the provider profile information form contained in Appendix 1 of the Contract.

3. Contiguous County Service Areas

   The Contractor may propose to provide service to counties through the use of provider networks in contiguous counties. The Contractor must identify the contiguous counties with an available provider network and the counties in the region that will be served through this provider network. A complete description of the provider network must be provided.

II-D MEDICAID ELIGIBILITY AND CHCP ENROLLMENT

The Michigan Medicaid program arranges for and administers medical assistance to approximately 1.4 million beneficiaries. This includes the categorically needy (those individuals eligible for, or receiving, federally-aided financial assistance or those deemed categorically needy) and the medically needy populations. Eligibility for Michigan's Medicaid program is based on a combination of financial and non-financial factors. Within the Medicaid eligible population, there are groups that must enroll in the CHCP, groups that may voluntarily enroll, and groups that are excluded from participation in the CHCP as follows:

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

2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:

   - Migrants
   - Native Americans
   - Persons in the Traumatic Brain Injury program
   - Pregnant women, whose pregnancy is the basis for Medicaid eligibility

3. Medicaid Eligible Groups Excluded From Enrollment in the CHCP:

   - Persons without full Medicaid coverage
   - Persons with Medicaid who reside in an ICF/MR (intermediate care facilities for the mentally retarded), or a State psychiatric hospital
   - Persons receiving long term care (custodial care) in a licensed nursing facility
   - Persons being served under the Home & Community Based Elderly Waiver

- Persons enrolled in Children's Special Health Care Services (CSHCS)
- Persons with commercial HMO coverage, including Medicare HMO coverage
- Persons in PACE (Program for All-inclusive Care for the Elderly)
- Spend-down clients
- Children in foster care or in Child Care Institutions
- Persons in the Refugee Assistance Program
- Persons in the Repatriate Assistance Program
- Persons with both Medicare and Medicaid eligibility

II-E ELIGIBILITY DETERMINATION

The State has the sole authority for determining whether individuals or families meet any of the eligibility requirements as specified for enrollment in the CHCP.

Individuals who attain eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 60 days post-partum or post-loss of pregnancy. Their newborns are usually guaranteed coverage for 60 days and may be covered for one full year.

II-F ENROLLMENT IN THE CHCP

1. Enrollment Services

   The State is required to contract for services to help beneficiaries make informed choices regarding their health care, assist with client satisfaction and access surveys, and assist beneficiaries in the appropriate use of the Contractor's complaint and grievance systems. DCH contracts with an Enrollment Services contractor to contact and educate general Medicaid and CSHCS beneficiaries about managed care and to enroll, disenroll, and change enrollment for these beneficiaries. Although this Contract indicates that the enrollment and disenrollment process and related functions will be performed by DCH, generally, these activities are part of the Enrollment Services contract. Enrollment Services references to DCH are intended to indicate functions that will be performed by either DCH or the Enrollment Services contractor. All Contractors agree to work closely with DCH and provide necessary information, including provider files.

2. Initial Enrollment

   After a person applies to FIA for Medicaid, she or he will be assessed for eligibility in a Medicaid managed care program. If they are determined eligible for the CHCP, they are given information on the Contractors available to them, and the opportunity to speak with an enrollee counselor to obtain more in-depth information and to get answers to any questions or concerns they may have. DCH provides access to a toll-free number to call for information or to designate their preferred Contractor. If beneficiaries do not reside in a county covered by the rural county exception or the preferred option exception, beneficiaries eligible for the CHCP will have full choice of Contractors within their county of residence. Beneficiaries must decide on the Contractor they wish to enroll in within 30 days from the date of approval of Medicaid eligibility. If they do not voluntarily choose a Contractor within 30 days of approval, DCH will automatically assign the beneficiaries to a Contractor within their county of residence.

   Under the automatic enrollment process, beneficiaries will be automatically assigned based on the Contractor’s performance in areas specified by DCH. DCH will automatically assign a larger proportion of beneficiaries to Contractors with a higher performance ranking. The capacity of the Contractor to accept new enrollees and to provide reasonable 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.

3. Enrollment Lock-in and Open Enrollment for Beneficiaries in Counties Not Covered by Exceptions

   Except as stated in this subsection, enrollment into a Contractor's plan will be for a period of 12 months with the following conditions:

   - During the annual open enrollment period, DCH, or the Enrollment Services contractor, will notify enrollees of their right to disenroll;
   - Enrollees will be provided with an opportunity to select any Contractor approved for their area during this open enrollment period;
   - Enrollees will be notified that if they do nothing, their current enrollment will continue;
   - Enrollees who choose to remain with the same Contractor will be deemed to have had their opportunity for disenrollment without cause and declined that opportunity until the next open enrollment period;
   - New enrollees or those who have changed from one Contractor to another will have 90 days within which they may change Contractors without cause;
   - Enrollees who change enrollment within the 90-day period will have another 90 days within which they may change Contractors without cause and this may continue throughout the year;
   - An enrollee who has already had a 90-day period with a particular Contractor will not be entitled to another 90-day period within the year with the same Contractor;
   - Enrollees who disenroll from a Contractor will be required to change enrollment to another Contractor;
   - All such changes will be approved and implemented by DCH on a calendar month basis.

4. Rural Area Exception

   In counties that are designated as rural counties, the DCH may implement a Rural Area Exception policy. The policy allows DCH to require mandatory enrollment of Medicaid beneficiaries into a single health plan that is the only health plan with service area approval in the respective rural county. This policy will only be implemented in counties that are designated as "rural" as defined by this Contract. Appendix 2 lists the counties in which the State has currently, or may in the future, implement the rural area exception.

   Enrollees must be permitted to choose from at least two primary care providers (PCPs). Enrollees must have the option of obtaining services from any other provider if the following conditions exist:

   - The type of service or specialist is not available within the HMO
   - The provider is not part of the network, but is the main source of a service to the enrollee
   - The only provider available to the enrollee does not, because of moral or religious objections, provide the service the enrollee seeks
   - Related services must be performed by the same provider and all of the services are not available within the network
   - The State determines other circumstances that warrant out of network treatment

   The State shall determine the rural counties to be part of this exception. The State will determine the method of Contractor selection and payment based on performance measures, provider network, current enrollment, and/or other factors relevant to the area.

5. Preferred Option Program

   In counties in which only one health plan is available for enrollment, DCH may implement a Preferred Option program. This allows DCH to use Contractor enrollment as the default enrollment option. Beneficiaries in mandatory enrollment categories are notified that they must choose between enrollment in the Contractor's health plan or

fee-for-service (FFS) Medicaid. If the beneficiary does not contact the enrollment broker by the specified deadline, the beneficiary is automatically enrolled with the Contractor. Beneficiaries assigned under the Preferred Option program are not locked into the Contractor's health plan and may disenroll at any time without cause.

6. Enrollment Date

   Any changes in enrollment will be approved and implemented by DCH on a calendar month basis. Health plans are responsible for members until the date of disenrollment.

   If a beneficiary is determined eligible during a month, he or she is eligible for the entire month. In some cases, enrollees may be retroactively determined eligible. Once a beneficiary (other than a newborn) is determined to be Medicaid eligible, enrollment with a Contractor will occur on the first day of the next available month following the eligibility determination and enrollment process. Contractors will not be responsible for paying for health care services during a period of retroactive eligibility and prior to the date of enrollment in their health plan, except for newborns (Refer to ITB Section II-F-7). Only full-month capitation payments will be made to the Contractor.

   If the beneficiary is in *any* inpatient hospital setting on the date of enrollment (first day of the month), the Contractor will not be responsible for the inpatient stay or any charges incurred prior to the date of discharge. The Contractor will be responsible for all care from the date of discharge forward. Similarly, if an enrollee is disenrolled from a Contractor and is in *any* inpatient hospital setting on the date of disenrollment (last day of the month), the Contractor will be responsible for all charges incurred through the date of discharge, subject to the exception for disenrollments based on Title V enrollment.

7. Newborn Enrollment

   Newborns of eligible CHCP mothers who were 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. 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. 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, the Contractor is responsible for submitting a newborn notification form to DCH.

8. Automatic Re-enrollment

   Enrollees who are disenrolled from a Contractor's plan due to loss of Medicaid eligibility or FIA action will be automatically re-enrolled prospectively to the same Contractor provided that they regain eligibility within three months.

9. Enrollment Errors by the Department

   If DCH enrolls a non-eligible person with a Contractor, DCH will retroactively disenroll the person as soon as the error is discovered and will recoup the capitation paid to the Contractor. Contractor may then recoup payments from its providers as allowed by Medicaid policy and as permissible under the Contractor's provider contracts.

10. Enrollees Who Move Out of the Contractor's Service Area

    The Contractor agrees to be responsible for services provided to an enrollee who has moved out of the Contractor's service area after the effective date of enrollment until the enrollee is disenrolled from the Contractor.

When requesting disenrollment, the Contractor must submit verifiable information that an enrollee has moved out of the service area. DCH will expedite prospective disenrollments of enrollees and process all such disenrollments effective the next available month after notification from FIA that the enrollee has left the Contractor's service area. Until the enrollee is disenrolled from the Contractor, the Contractor will receive a capitation rate for these enrollees at the rate approved for the county to which the enrollee moved. The Contractor is responsible for all medically necessary covered and authorized services for these enrollees until they are disenrolled. The Contractor may use its utilization management protocols for hospital admissions and specialty referrals for enrollees in this situation. Contractors may require enrollees to return to use network providers and provide transportation and/or Contractors may authorize out of network providers to provide medically necessary services. Enrollment of beneficiaries who reside out of the service area of a Contractor before the effective date of enrollment will be considered an "enrollment error" as described above.

11. Disenrollment Requests Initiated by the Contractor

The Contractor may initiate special disenrollment requests to DCH based on enrollee actions inconsistent with Contractor membership—for example, if there is fraud, abuse of the Contractor, or other intentional misconduct; or if, in the opinion of the attending PCP, the enrollee's behavior makes it medically infeasible to safely or prudently render covered services to the enrollee. Health plans are responsible for members until the date of disenrollment. Special disenrollment requests are divided into three categories:

- Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against Contractor providers, staff, or the public at Contractor locations; or stalking situations.
- Fraud/misrepresentation involving alteration or theft of prescriptions, misrepresentation of Contractor membership, or unauthorized use of CHCP benefits.
- Other noncompliance situations involving the failure to follow treatment plan; repeated use of non-Contractor providers; discharge from the practices of available Contractor's network providers; repeated emergency room use; and other situations that impede care.

The Contractor may also initiate disenrollment requests if the enrollee becomes medically eligible for services under Title V of the Social Security Act or is admitted to a nursing facility for custodial care. The Contractor must provide DCH with medical documentation to support this type of disenrollment request. Information must be provided in a timely manner using the format specified by DCH. DCH reserves the right to require additional information from the Contractor to assess the need for enrollee disenrollment and to determine the enrollee's eligibility for special services. Health plans are responsible for members until the date of disenrollment.

12. Medical Exception

The beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the Contractor at the time of enrollment. The beneficiary must submit a medical exception request to DCH.

13. Disenrollment for Cause Initiated by the Enrollee

The enrollee may request a disenrollment for cause from a Contractor's plan at any time during the enrollment period. Reasons cited in a request for disenrollment for cause may include poor quality care or lack of access to necessary specialty services covered under the Contract. Beneficiaries must demonstrate that adequate care is not available by providers within the Contractor's provider network. Further criteria, as necessary, will be developed by DCH. Enrollees who are granted a disenrollment for cause will be required to change enrollment to another Contractor when another Contractor is available.

II-G SCOPE OF COMPREHENSIVE BENEFIT PACKAGE

1. Services Included

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section I-Z.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially, pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

2. Enhanced Services

In conjunction with the provision of covered services, the Contractor agrees to do the following:

- Place strong emphasis on programs to enhance the general health and well-being of enrollees;
- Make health promotion programs available to the enrollees;
- Promote the availability of health education classes for enrollees;
- Provide education for enrollees with, or at risk for, a specific disability or illness;
- Provide education to enrollees, enrollees' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities.

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

The Contractor may not charge an enrollee a fee for participating in health education services that fall under the definition of a covered service under this section of the Contract. A nominal fee may be charged to an enrollee if the enrollee elects to participate in programs beyond the covered services.

3. Services Covered Outside of the Contract

The following services are not Contractor requirements:

- Dental services
- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services (Contractors are not responsible for the physician cost related to providing psychiatric admission histories and physical. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the Contractor would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Outpatient partial hospitalization psychiatric care
- Mental health services in excess of 20 outpatient visits each contract year
- Substance abuse services through accredited providers including:
  - Screening and assessment
  - Detoxification
  - Intensive outpatient counseling and other outpatient services
  - Methadone treatment
- Services provided to persons with developmental disabilities and billed through Provider Type 21
- Custodial care in a nursing facility
- Home and Community based waiver program services
- Personal care or home help services
- Transportation for services not covered in the CHCP

4. Services Prohibited or Excluded Under Medicaid:

- Elective abortions and related services
- Experimental/Investigational drugs, procedures or equipment
- Elective cosmetic surgery

II-H SPECIAL COVERAGE PROVISIONS

Specific coverage and payment policies apply to certain types of services and providers, including the following:

- Emergency services
- Out-of-network services
- Family planning services
- Maternal and Infant Support Services
- Federally Qualified Health Center (FQHC)

- Co-payments
- Abortions
- Pharmacy services
- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program
- Immunizations
- Transportation
- Transplant services
- Communicable disease services
- Restorative health services
- Child and Adolescent Health Centers and Programs
- Hospice Services
- Mental Health Services

1. Emergency Services

The Contractor must cover emergency services as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)). The enrollee must be screened and stabilized without requiring prior authorization.

The Contractor must ensure that emergency services are available 24 hours a day and 7 days a week. The Contractor is responsible for payment of all out-of-plan or out-of-area emergency services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services. The Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.

(a) Emergency Transportation

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

(b) Professional Services

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

(c) Facility Services

The Contractor agrees to ensure that emergency services continue until the enrollee is stabilized and can be safely discharged or transferred. If an enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services. However, such services shall be deemed prior authorized if the Contractor does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 for responding to a request for authorization being made by the emergency department.

2. Out-of-Network Services

   If medically necessary, the Contractor may authorize services either out-of-network or out-of-area. Unless otherwise noted in this Contract, the Contractor is responsible for coverage and payment of all emergency and authorized covered services provided outside of the established network. Out-of-network claims must be paid at established Medicaid fees in effect on the date of service for paying participating Medicaid providers as established by Medicaid policy.

3. Family Planning Services

   Family planning services include any medically approved diagnostic evaluation, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases (STDs). Services are to be provided in a confidential manner to individuals of child bearing age including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or wish to limit the number and spacing of their children.

   The Contractor agrees to:

   - Ensure that enrollees have full freedom of choice of family planning providers, both in-network and out-of-network
   - Encourage the use of public providers in their network;
   - Pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service, at established Medicaid FFS fees in effect on the date of service paid to participating Medicaid providers;
   - Encourage family planning providers to communicate with PCPs once any form of medical treatment is undertaken;
   - Maintain accessibility for family planning services through promptness in scheduling appointments, particularly for teenagers;
   - Make certain that Medicaid funding is not utilized for services for the treatment of infertility.

4. Maternal and Infant Support Services

   The Contractor agrees that:

   (a) Maternal and infant support services are preventive services provided to pregnant women, mothers and their infants to help reduce infant mortality and morbidity;
   (b) The support services are intended for those enrollees who are most likely to experience serious health problems due to psychosocial or nutritional conditions;
   (c) These support services are provided by a multidisciplinary team of health professionals qualified in social work, nutrition, health education, and counseling;
   (d) Maternal and infant support services providers must be certified by MDCH.
   (e) The Contractor will ensure that the mothers and infants have access to support services for the following:
      - Proper nutrition,
      - Psychosocial support,
      - Transportation for health services, as needed,
      - Assistance in understanding the importance of receiving routine prenatal care, well child visits and immunizations, as well as other necessary health services,
      - Care coordination, counseling, and social casework,
      - Enrollee advocacy, and
      - Appropriate referral services;

   The Contractor agrees that during the course of providing maternal or infant care, support services will be provided if any of the following conditions are likely to affect the pregnancy:

   - Homeless or dangerous living/home situation
   - Negative or ambivalent feelings about the pregnancy

- Mother under age 18 and has no family support
- Need for assistance to care for herself and infant
- Mother with cognitive emotional or mental impairment
- Nutrition problem
- Need for transportation to keep medical appointments
- Need for childbirth education
- Abuse of alcohol or drugs
- Tobacco use

The Contractor agrees that infant support services are home-based services and will be provided if any of the following conditions exist with the mother or infant:

- Abuse of alcohol or drugs
- Tobacco use
- Mother is under age 18 and has no family support
- Family history of child abuse or neglect
- Failure to thrive
- Low birth weight (less than 2500 grams)
- Mother with cognitive, emotional or mental impairment
- Homeless or dangerous living/home situation
- Any other condition that may place the infant at risk for death, illness or significant impairment

Due to the potentially serious nature of these conditions, some enrollees will need the assistance of the local FIA Children's Protective Services (CPS). The Contractor agrees to work cooperatively and on an ongoing basis to facilitate the monitoring and coordination of care, referral, and follow-up for CPS.

5. Federally Qualified Health Centers (FQHCs)

The Contractor agrees to provide enrollees with access to services provided through an FQHC if the enrollee resides in the FQHC's service area and if the enrollee requests such services. For purposes of this requirement, the service area will be defined as the county in which the FQHC is located. The Contractor must inform enrollees of this right in their member handbooks.

If a Contractor has an FQHC in its provider network and allows members to receive medically necessary services from the FQHC, the Contractor has fulfilled its responsibility to provide FQHC services and does not need to allow enrollees to access FQHC services out-of-network.

If a Contractor does not include an FQHC in the provider network and an FQHC exists in the service area (county), the Contractor must allow enrollees to receive services from the out-of-network FQHC(s). FQHC services must be prior authorized by the Contractor; however, the Contractor may not refuse to authorize medically necessary services if the Contractor does not have an FQHC in the network for the service area (county). The Social Security Act requires that Contractors pay the FQHCs at least as much as the Contractor pays to a non-FQHC provider for the same service. Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs. FQHCs are entitled, pursuant to the Social Security Act, to prospective payment reimbursement through annual reconciliation with the DCH. Michigan is required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903 (m) organizations (Health Plans) and the reasonable cost of FQHC subcontracts with the 1903 (m) organization.

6. Co-payments

The Contractor may require co-payments by enrollees, consistent with state and federal guidelines. The Contractor agrees that it will not implement co-payments without DCH approval and that co-payments will only be implemented following the annual open enrollment period. Enrollees must be informed of co-payments during the open enrollment period.

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

7. Abortions

Medicaid funds cannot be used to pay for elective abortions (and related services) to terminate pregnancy unless one of the following conditions is met:

- A physician certifies that the abortion is medically necessary to save the life of the mother.
- The pregnancy is a result of rape or incest
- Treatment is for medical complications occurring as a result of an elective abortion
- Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy

8. Pharmacy

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

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

(b) Pharmacy carve out

The Contractor is not responsible for: (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. These medications will be reimbursed by MDCH's pharmacy TPA, First Health, through a point-of-service reimbursement system.

(c) Other Psychotropic Pharmacy Services

The Contractor agrees to act as DCH's third party administrator and reimburse pharmacies for psychotropic drugs not list in the drug classifications specified above. In the performance of this function:

1. The Contractor must follow Medicaid FFS utilization controls for Medicaid psychotropic prescriptions. The Contractor must follow Medicaid FFS policy for prior authorization on all psychotropic medications.
2. The Contractor agrees that it and its pharmacy benefit managers are precluded from billing manufacturer rebates on psychotropic drugs.
3. The Contractor agrees to provide payment files to DCH in the format and manner prescribed by DCH available at www.michigan.fhsc.com/Documents.
4. DCH agrees to use the payment files to reimburse the Contractor for 60% of the Medicaid fee according to the Medicaid pharmaceutical reimbursement policy
5. The Contractor is responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for enrollees but may limit access to its contracted lab and x-ray providers.

9. Well Child Care/Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program

Well Child/EPSDT is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. It supports two goals: to ensure access to necessary health resources, and to assist parents and guardians in appropriately using those resources. The Contractor agrees to provide the following EPSDT services:

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

- Health and developmental history
- Developmental/behavioral assessment
- Age appropriate unclothed physical examination
- Height and weight measurements, and age appropriate head circumference
- Blood pressure for children 3 and over
- Immunization review and administration of appropriate immunizations
- Health education including anticipatory guidance
- Nutritional assessment
- Hearing, vision and dental assessments
- Blood lead testing for children under 6 years of age
- Interpretive conference and appropriate counseling for parents or guardians

Additionally, objective testing for developmental behavior, hearing, and vision must be performed in accordance with the Medicaid periodicity schedule. Laboratory services for tuberculin, hematocrit, hemoglobin, urinalysis, or other needed testing as determined by the physician must be provided.

(b) The Contractor agrees to provide the following EPSDT services:

- Vision services under Well Child/EPSDT must include at least diagnosis and treatment for defective vision, including glasses if appropriate.
- Dental services under Well Child/EPSDT must include at least relief of pain and infections, restoration of teeth, and maintenance of dental health. (The Contractor is responsible for screening and referral only.)
- Hearing services must include at least diagnosis and treatment for hearing defects, including hearing aids as appropriate.
- Other health care, diagnostic services, treatment, or services covered under the State Medicaid Plan necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening. A medically necessary service may be available under Well Child/EPSDT if listed in a federal statute as a potentially covered service, even if Michigan's Medicaid program does not cover the service under its State Plan for Medical Assistance Program.

Appropriate referrals must be made for a diagnostic or treatment service determined to be necessary.

- Oral screening should be part of a physical exam; however, each child must have a direct referral to a dentist after age two.
- Children should also be referred to a hearing and speech clinic, optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services as necessary.
- Referral to community mental health services also may be appropriate.
- If a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, a referral should be made to the local health department for follow-up services that may include an epidemiological investigation to determine the source of blood lead poisoning.

(d) Outreach

The Contractor shall provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for well-child visits. Outreach contacts may be by phone, home visit, or mail.

The Contractor will meet this requirement by contracting with other organizations and non-profit agencies that have a demonstrated capacity of reaching the Well Child/EPSDT target population.

10. Immunizations

The Contractor agrees to provide enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. The Contractor must ensure that all providers use vaccines available free under the Vaccine for Children (VFC) program for children 18 years old and younger, and use vaccines for adults such as hepatitis B available at no cost from local health departments under the Michigan Vaccine Replacement Program. Immunizations should be given in conjunction with Well-Child/EPSDT care. The Contractor must participate in the local and state immunization initiatives/programs. Contractors must also facilitate and monitor provider participation with the Michigan Children's Immunization Registry (MCIR). MCIR is a database of child vaccination histories that enables immunization tracking and recall. Contractors are responsible for the reimbursement of administration fees for immunizations that enrollees have obtained from local health departments at Medicaid-FFS rates. This policy is effective without Contractor prior authorization and regardless of whether a contract exists between the Contractor and the local health departments.

11. Transportation

The Contractor must ensure transportation and travel expenses determined to be necessary for enrollees to secure medically necessary medical examinations and treatment. Contractors may utilize FIA guidelines for 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.

12. Transplant Services

The Contractor agrees to cover all costs associated with transplant surgery and care. Related care may include but is not limited to organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs. Cornea and kidney transplants and related procedures are covered services. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous and peripheral stem cell harvesting, and small bowel) must be covered on a patient-specific basis when determined medically necessary according to currently accepted standards of care. The Contractor must have a process in place to evaluate, document, and act upon such requests.

13. Communicable Disease Services

The Contractor agrees that enrollees may receive treatment services for communicable diseases from local health departments without prior authorization by the Contractor. For purposes of this section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

To facilitate coordination and collaboration, Contractors are encouraged to enter into agreements or contracts with local health departments. Such agreements or contracts should provide details regarding confidentiality, service coordination and instances when local health departments will provide direct care services for the Contractor's enrollees. Agreements should also discuss, where appropriate, reimbursement arrangements between the Contractor and the local health department. If a local agreement is not in effect, and an enrollee receives services for a communicable disease from a local health department, the Contractor is responsible for payment to the local health department at established Medicaid FFS rates in effect on the date of service.

14. Restorative Health Services

Restorative health services means intermittent or short-term "restorative" or rehabilitative nursing care that may be provided in or out of licensed nursing facilities. The Contractor is responsible for providing up to 45 days of intermittent or short-term restorative or rehabilitative services in a nursing facility as long as medically necessary and appropriate for enrollees. The 45-day maximum does not apply to restorative health services provided in places of service other than a nursing facility.

The Contractor is expected to help facilitate support services such as home help services that are not the direct responsibility of the Contractor but are services to which enrollees may be entitled. Such care coordination should be provided consistent with the individual or person-centered planning that is necessary for enrollee members with special health care needs.

15. Child and Adolescent Health Centers and Programs

The Contractor acknowledges that enrollees may choose to obtain covered services from a Child and Adolescent Health Centers and Programs (CAHCPs) provider without prior authorization from the Contractor. If the CAHCP does not have a contractual relationship with the Contractor, then the Contractor is responsible for payment to the CAHCP at Medicaid FFS rates in effect on the date of service.

Contractors may contract with a CAHCP to deliver covered services as part of the Contractor's network. If the CAHCP is in the Contractor's network, the following conditions apply:

- Covered services shall be medically necessary and administered, or arranged for, by a designated PCP.
- The CAHCP will meet the Contractor's written credentialing and re-credentialing policies and procedures for ensuring quality of care and ensuring that all providers rendering services to enrollees are licensed by the State and practice within their scope of practice as defined for them in Michigan's Public Health Code.
- The Contractor must reimburse the CAHCP according to the provisions of the contractual agreement.

16. Hospice Services

The Contractor is responsible for all medically necessary and authorized hospice services, including the "room and board" component of the hospice benefit when provided in a nursing home or hospital. Members who have elected the hospice benefit will not be disenrolled after 45 days in a nursing home as otherwise permitted under ITB Section II-H-14.

17. Twenty (20) Visit Mental Health Outpatient Benefit

The Contractor shall provide the 20 Visit Mental Health Outpatient Benefit consistent with the policy and procedures established by Medicaid policy. Services may be provided through contracts with Community Mental Health Services Programs (CMHSP), Pre-paid Inpatient Hospital Plans (PIHPs), or through contracts with other appropriate providers within the service area.

II-I OBSERVANCE OF FEDERAL, STATE, AND LOCAL LAWS

The Contractor agrees that it will comply with all state and federal statutes, regulations and administrative procedures that become effective during the term of this Contract. Federal regulations governing contracts with risk-based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434, and will govern this Contract. The State is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Contract Section (I-Z).

1. Special Waiver Provisions for CHCP

   CMS has granted DCH a waiver under Section 1915(b)(1)(2), granting that section 1902 (a)(23) of the Social Security Act be waived. The waiver covers the period April 22, 2003 through April 22, 2005. Under this waiver, beneficiaries will be enrolled with a Contractor in the county of their residence. All health care for enrollees will be arranged for or administered only by the Contractor. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this Contract. No other waiver is necessary to implement this Contract.

2. Fiscal Soundness of the Risk-Based Contractor

   Federal regulations (42 CFR 438.116) require that the risk-based Contractors maintain a fiscally solvent operation. To this end, Contractors must comply with all HMO statutory requirements for fiscal soundness and DCH will evaluate the Contractor's financial soundness based upon the thresholds established in Appendix 3 of this Contract. If the Contractor does not maintain the minimum statutory financial requirements, DCH will apply remedies and sanctions according to section II-V of this Contract, including termination of the contract.

3. Prohibited Affiliations with Individuals De-barred by Federal Agencies

   Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. An enrollee may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds may be used. DCH publishes a list of providers who are terminated, suspended, or otherwise excluded from participation in the program. The Contractor must ensure that its provider networks do not include these providers.

   Pursuant to Section 42 CFR 438.610, a Contractor may not knowingly have a director, officer, partner, or person with beneficial ownership of 5% or more of the entity's equity who is currently debarred or suspended by any state or federal agency. Contractors are also prohibited from having an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State. The United States General Services Administration (GSA) also maintains a list of parties excluded from federal programs. The Excluded Parties Listing System (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's homepage at the following Internet address: www.arnet.gov/epls.

4. Public Health Reporting

   State law requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The Contractor agrees to require compliance with all such reporting requirements in its provider contracts.

5. Compliance with CMS Regulation

   Contractors are required to comply with all CMS regulations, including, but not limited to, the following:

   - Enrollment and Disenrollment: As required by 42 CFR 438.56, Contractors must meet all the requirements specified for enrollment and disenrollment limitations.
   - Provision of covered services: As required by 42 CFR 438.102(a)(2), Contractors are required to provide all covered services listed in Section II-G and II-H of the contract.

6. Compliance with HIPAA Regulation

   The Contractor shall comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 by the required deadlines. This includes designation of specific individuals to serve as the HIPAA privacy and HIPAA security officers.

7. Advanced Directives Compliance

   The Contractor shall comply with all provisions for advance directives (described in 42 CFR 422.128) as required under 42 CFR 438.6. The Contractor must have in effect, written policies and procedures for the use and handling of advance directives written for any adult individual receiving medical care by or through the Contractor. The policies and procedures must include at least the following provisions:

   - The enrollees' right to have and exercise advance directives under the law of the State of Michigan, [MCL 700.5506-700.5512 and MCL 333.1051-333.1064]. Changes to State law must be updated in the policies no later than 90 days after the changes occur, if applicable.
   - The Contractor's procedures for respecting those rights, including any limitations if applicable

8. Medicaid Policy

   As required, Contractors shall comply with provisions of Medicaid policy applicable to MHPs developed under the formal policy consultation process, as established by the Medical Assistance Program.

II-J CONFIDENTIALITY

All enrollee information, medical records, data and data elements collected, maintained, or used in the administration of this Contract shall be protected by the Contractor from unauthorized disclosure. The Contractor must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with its administration of the Contract.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services.

II-K CRITERIA FOR CONTRACTORS

The Contractor agrees to maintain its capability to deliver covered services to enrollees by meeting the following general criteria. Subsequent sections of the Contract contain specific criteria in each of these areas.

1. Administrative and Organizational Criteria

   The Contractor will:

   - Provide organizational and administrative structure and key specified personnel;
   - Provide management information systems capable of collecting processing, reporting and maintaining information as required;
   - Have a governing body that meets the requirements defined in this Contract;
   - Meet the specified administrative requirements, i.e., quality improvement, utilization management, provider network, reporting, member services, provider services, and staffing;

- 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). 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.
- Be incorporated within the State of Michigan and have a Certificate of Authority to operate as a Health Maintenance Organization (HMO) in the State of Michigan in accordance with MCL 500.3505.

2. Financial Criteria

   The Contractor agrees to comply with all HMO financial requirements and maintain financial records for its Medicaid activities separate from other financial records.

3. Provider Network and Health Service Delivery Criteria

   In general, the Contractor must do the following:

   - Maintain a network of qualified providers in sufficient numbers and locations to provide required access to covered services;
   - Provide or arrange accessible care 24 hours a day, 7 days a week to the enrolled population.
   - Develop and maintain local agreements with DCH contracted behavioral health and developmental disability providers that facilitate the coordination of care.
   - Comply with Medicaid Policy regarding requirements for authorization and reimbursement for out of network providers.

II-L CONTRACTOR ORGANIZATIONAL STRUCTURE, ADMINISTRATIVE SERVICES, FINANCIAL REQUIREMENTS AND PROVIDER NETWORKS

1. Organizational Structure

   The Contractor will maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program. The Contractor's management approach and organizational structure will ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, grievance/appeal review, and management information systems.

   The Contractor will be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. The Contractor will employ senior level managers with sufficient experience and expertise in health care management, and must employ or contract with skilled clinicians for medical management activities.

   The Contractor will provide a copy of the current organizational chart with reporting structures, names, and positions to DCH upon request. The Contractor must also provide a written narrative that documents the educational background, applicable licensure, relevant work experience, and current job description for the key personnel identified in the organizational chart.

The Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its provider network or in the conduct of the Contractor's affairs. The Contractor will not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes all individuals responsible for the conduct of the Contractor's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

The Contractor will provide to DCH, upon request, a notarized and signed disclosure statement fully disclosing the nature and extent of any contracts or arrangements between the Contractor or a provider or other person concerning any financial relationship with the Contractor and any one of the following:

- The individuals responsible for the conduct of the Contractor's affairs, or
- Their immediate families, or
- Any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity

DCH must be notified in writing of a substantial change in the facts set forth in the statement not more than 30 days from the date of the change.

Information required to be disclosed in this section shall also be available to the Department of Attorney General, Health Care Fraud Division.

2. Administrative Personnel

The Contractor will have sufficient administrative staff and organizational components to comply with all program standards. The Contractor shall ensure that all staff has appropriate training, education, experience, licensure as appropriate, liability coverage, and orientation to fulfill the requirements of the positions. Resumes for key personnel must be available upon request from DCH. Resumes must indicate the type and amount of experience each person has relative to the position. DCH will evaluate the sufficiency and competency of the Contractor's administrative personnel when considering Contractor's services area and enrollment expansion requests.

The Contractor must promptly provide written notification to DCH of any vacancies of key positions and must make every effort to fill vacancies in all key positions with qualified persons as quickly as possible. The Contractor shall inform DCH in writing within seven (7) days of staffing changes in the following key positions:

- Administrator (Chief Executive Officer)
- Medical Director
- Chief Financial Officer
- Management Information System Director

The Contractor shall provide the following positions (either through direct employment or contract):

(a) Executive Management

The Contractor must have a full time administrator with clear authority over general administration and implementation of requirements set forth in the Contract including responsibility to oversee the budget and accounting systems implemented by the Contractor. The administrator shall be responsible to the governing body for the daily conduct and operations of the Contractor's plan.

(b) Medical Director

The medical director shall be a Michigan-licensed physician (MD or DO) and shall be actively involved in all major clinical program components of the Contractor's plan including review of medical care provided, medical professional aspects of

provider contracts, and other areas of responsibility as may be designated by the Contractor. The medical director shall devote sufficient time to the Contractor's plan to ensure timely medical decisions, including after hours consultation as needed. The medical director shall be responsible for managing the Contractor's Quality Assessment and Performance Improvement Program. The medical director shall ensure compliance with state and local reporting laws on communicable diseases, child abuse, and neglect.

(c) Quality Improvement and Utilization Director

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.

(d) Chief Financial Officer

The Contractor must provide a full-time chief financial officer who is responsible for overseeing the budget and accounting systems implemented by the Contractor.

(e) Support/Administrative Staff

The Contractor must have adequate clerical and support staff to ensure appropriate functioning of the Contractor's operation.

(f) Member Services Director

The Contractor must an individual responsible for coordinating communications with enrollees and other enrollee services such as acting as an enrollee advocate. There shall be sufficient member service staff to enable enrollees to receive prompt resolution of their problems or inquiries.

(g) Provider Services Director

The Contractor must provide an individual responsible for coordinating communications between the Contractor and its subcontractors and other providers. There shall be sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.

(h) Grievance/Complaint Coordinator

The Contractor must provide staff to coordinate, manage, and adjudicate member and provider grievances.

(i) Management Information System (MIS) Director

The Contractor's MIS director must be a full-time position that oversees and maintains the data management system that is capable of adequate data collection and processing, timely and accurate reporting, and correct claims payments.

(j) Compliance Officer

The Contractor must provide a full-time compliance officer to oversee the Contractor's compliance plan and to verify that fraud and abuse is reported in accordance with the guidelines as outlined in 42 CFR 438.608.

(k) Designated Liaisons

The Contractor must provide a management information system (MIS) liaison and a general management liaison. All communication between the Contractor and DCH must occur through the designated liaisons unless otherwise specified by DCH.

3. Administrative Requirements

The Contractor agrees to develop and maintain the following written policies, processes, and plans:

- Policies, procedures and an operational plan for management information systems;
- Process to review and authorize all network provider contracts;
- Policies and procedures for credentialing and monitoring credentials of all healthcare personnel;
- Policies and procedures for identifying, addressing, and reporting instances of fraud and abuse;
- Process to review and authorize contracts established for reinsurance and third party liability if applicable;
- Policies to ensure compliance with all federal and state business requirements.

All policies, procedures, and clinical guidelines that the Contractor follows must be in writing and available upon request to DCH and/or CMS. All medical records, reporting formats, information systems, liability policies, provider network information and other detail specific to performing the contracted services must be available on request to DCH and/or CMS.

4. 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

When reporting suspected fraud and/or abuse, the Contractor should provide to the DCH the following information:

- Nature of the complaint

- The name of the 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

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.

5. Management Information Systems

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

(a) Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by the State through an encounter data system;
(b) Supporting provider payments and data reporting between the Contractor and DCH;
(c) Controlling, processing, and paying providers for services rendered to Contractor enrollees;
(d) Collecting service-specific procedures and diagnosis data, collecting price specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintaining detailed records of remittances to providers;
(e) Supporting all Contractor operations, including, but not limited to, the following:

- Member enrollment, disenrollment, and capitation payments
- Utilization
- Provider enrollment
- Third party liability activity
- Claims payment
- Grievance and appeal tracking
- Tracking and recall for immunizations, well-child visits/EPSDT, and other services as required by DCH
- Encounter reporting
- Quality reporting
- Member access and satisfaction

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

- Verifying the accuracy and timeliness of the data;
- Screening the data for completeness, logic, and consistency;
- Collecting service information in standardized formats;
- Identification and tracking of fraud and abuse.

The Contractor is responsible for annual IRS form 1099 reporting of provider earnings and must make all collected data available to the State and, upon request, to CMS.

6. Governing Body

Each Contractor will have a governing body. The governing body will ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor will be responsible to the governing body. The governing body must meet at least quarterly, and must keep a permanent record of all proceedings that is available to DCH and/or CMS upon request.

A minimum of 1/3 of the membership of the governing body must consist of adult enrollees who are not compensated officers, employees, stockholders who own 5% or more of the equity in the Contractor's plan, or other individuals responsible for the

conduct of, or financially interested in, the Contractor's affairs. The Contractor must have written policies and procedures for governing body elections detailing, at a minimum, the following:

- How enrollee board members will be elected
- The length of the term for board members
- Filling of vacancies
- Notice to enrollees

The enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan.

7. Provider Network

(a) General

The Contractor is solely responsible for arranging and administering covered services to enrollees. Covered services shall be medically necessary and administered, or arranged for, by a designated PCP. The Contractor must demonstrate that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of the enrollees within each enrollment area. The delivery system (in and out of network) must include adequate numbers of providers with the training, experience, and specialization to furnish the covered services listed in Sections II-G and II-H of this contract to all enrollees.

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

The Contractor's provider network must meet the following requirements:

- The Contractor shall have at least one full-time PCP per 2,000 members. This ratio shall be used to determine maximum enrollment capacity for the Contractor in an approved service area.
- Provides available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services with adequate numbers of provider locations with provisions for physical access for enrollees with physical disabilities;
- 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 reasonable access to specialists based on the availability and distribution of such specialists. 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;
- Provides adequate access to ancillary services such as pharmacy services, durable medical equipment services, home health services, and Maternal and Infant Support Services;
- Utilizes arrangements for laboratory services only through those laboratories with CLIA certificates;
- Contains only ancillary providers and facilities appropriately licensed or certified if required pursuant to the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211;

- Responds to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the Medicaid population;
- Selected PCPs are accessible taking into account travel time, availability of public transportation, and other factors that may determine accessibility;
- Primary care and hospital services are available to enrollees within 30 minutes or 30 miles travel. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minutes or 30 miles travel time. For pharmacy services, the State's expectations are that the Contractor will ensure access within 30 minutes travel time and that services will be available during evenings and on weekends;
- Contracted PCPs provide or arrange for coverage of services 24 hours a day, 7 days a week;
- PCPs must be available to see patients a minimum of 20 hours per practice location per week.

Provider files will be used to give beneficiaries information on available Contractors and to ensure that the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation. The Contractor will comply with the following:

- Submit provider files that contain a complete description of the provider network available to enrollees, according to the specifications and format delineated by DCH, to DCH's Enrollment Services contractor;
- Update provider files as necessary to reflect the changes in the existing provider network;
- Submit a provider file to DCH's Enrollment Services contractor at least once per month and more frequently if necessary to ensure that changes in the Contractor's provider network are reflected in the provider file in a timely manner;

(b) Inclusion

DCH considers inclusion of enrollees into the broader health delivery system to be important. The Contractor must have written guidelines and a process in place to ensure that enrollees are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. In addition, the Contractor must ensure that:

- Enrollees will not be denied a covered service or availability of a facility or provider identified in this Contract.
- Network providers will not intentionally segregate enrollees in any way from other persons receiving health care services.

(c) Coordination of Care with Public and Community Providers and Organizations

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

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

It is also beneficial for Contractors to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community.

For example, child and adolescent health centers and programs are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

(d) Coordination of Care with Local Behavioral Health and Developmental Disability Providers

Some enrollees may also be eligible for services provided by Behavioral Health Services and Services for Persons with Developmental Disabilities managed care programs. Contractors are not responsible for the direct delivery of specified behavioral health and developmental disability services as delineated in Medicaid policy. However, the Contractor must establish and maintain agreements with local behavioral health and developmental disability agencies or organizations contracting with the State.

Agreements between the Contractor and the Local Behavioral Health and Development Disability managed care providers must address the following issues:

- Emergency services
- Pharmacy and laboratory service coordination
- Medical 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.

(e) Network Changes

Contractors will notify DCH within seven (7) days of any changes to the composition of the provider network that affects the Contractor's ability to make available all covered services in a timely manner. Contractors will have written procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that DCH determines to negatively affect enrollees' access to covered services may be grounds for service area termination or sanctions, including Contract termination.
If the Contractor expands the PCP network within a county and can serve more enrollees, the Contractor may submit a request to DCH to increase capacity. The request must include details of the changes that would support the increased capacity. Contractor must use the format specified by DCH to describe network capacity.

(f) Provider Contracts

In addition to HMO licensure/certification requirements, Contractor provider contracts will meet the following criteria:

- Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles can be collected from enrollees. Co-payments are only permitted with DCH approval.
- Require the provider to cooperate with the Contractor's quality improvement and utilization review activities.
- Include provisions for the immediate transfer of enrollees to another Contractor PCP if their health or safety is in jeopardy.
- Include provisions stating that providers are not prohibited from discussing treatment options with enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.

- Include provisions stating that providers are not prohibited from advocating on behalf of the enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
- Require providers to meet Medicaid accessibility standards as defined in this contract.
- Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider.
- 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.

In accordance with Section 1932 (b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Contractors may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Contractors from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision also does not interfere with measures established by Contractors that are designed to maintain quality and control costs consistent with the responsibility of the organization.

(g) Disclosure of Physician Incentive Plan

Contractors will disclose to DCH, upon request, the information on their provider incentive plans listed in 42 CFR 422.208 and 422.210, as required in 42 CFR 438.6(h). The incentive plans must meet the requirements of 42 CFR 422.208-422.210 when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903 (s) of the Social Security Act. Upon request, the Contractor will provide the information on its physician incentive plans listed in 42 CFR 422.208 and 422.210 to any enrollee.

(h) Provider Credentialing

The Contractor will have written credentialing and re-credentialing policies and procedures for ensuring quality of care and ensuring that all providers rendering services to enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract. The Contractor must re-credential providers at least every 3 years. The Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. The Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards. If the plan declines to include providers in the plan's network, the plan must give the affected providers written notice of the reason for the decision.

(i) Primary Care Provider (PCP) Standards

The Contractor must offer enrollees freedom of choice in selecting a PCP. The Contractor will have written policies and procedures describing how enrollees choose and are assigned to a PCP, and how they may change their PCP. The Contractor will permit enrollees to choose a clinic as a PCP provided that the provider files submitted to DCH's Enrollment Services Contractor is completed consistent with DCH requirements.

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each enrollee's health care, and maintaining the enrollee's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services. A PCP may be any of the following: family practice physician, general practice physician,

internal medicine physician, OB/GYN specialist, or pediatric physician when appropriate for

an Enrollee, other physician specialists when appropriate for an Enrollee's health condition, nurse practitioner, and physician assistants.

The Contractor will allow a specialist to perform as a PCP when the enrollee's medical condition warrants management by a physician specialist. This may be necessary for those enrollees with conditions such as diabetes, end-stage renal disease, HIV/AIDS, or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the enrollee. If the enrollee disagrees with the Contractor's decision, the enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file a Fair Hearing Request with DCH.

The Contractor will ensure that there is a reliable system for providing 24-hour access to urgent care and emergency services 7 days a week. All PCPs within the network must have information on this system and must reinforce with their enrollees the appropriate use of the health care delivery system. Routine physician and office visits must be available during regular and scheduled office hours. The Contractor will ensure that some providers offer evening and weekend hours of operation in addition to scheduled daytime hours. The Contractor will provide notice to enrollees of the hours and locations of service for their assigned PCP.

Provisions must be available for obtaining urgent care 24 hours a day. Urgent care may be provided directly by the PCP or directed by the Contractor through other arrangements. Emergency services must always be available.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

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

PCPs must be available to see enrollees a minimum of 20 hours per practice location per week. This provision may be waived by DCH in response to a request supported by appropriate documentation. Specialists are not required to meet this standard for minimum hours per practice location per week. In the event that a specialist is assigned to act as a PCP, the enrollee must be informed of the specialist's business hours. In circumstances where teaching hospitals use residents as providers in a clinic and a supervising physician is designated as the PCP by the Contractor, the supervising physician must be available at least 20 hours per practice location per week.

The Contractor will monitor waiting times to get appointments with providers, as well as the length of time actually spent waiting to see the provider. This data must be reported to DCH upon request. The Contractor will have established criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to DCH upon request.

The Contractor will ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and postpartum care. A maternity care provider is a provider meeting the Contractor's credentialing requirements and whose scope of practice includes maternity care. An individual provider must be named as the maternity care provider to assure continuity of care. An OB/GYN clinic or practice cannot be designated as a PCP or maternity care provider. Designation of individual providers within a clinic or practice is appropriate as long as that individual, within the clinic or practice, agrees to accept responsibility for the enrollee's care for the duration of the pregnancy and post-partum care.

For maternity care, the Contractor must provide initial prenatal care appointments for enrolled pregnant women according to standards developed by the CAC and the Contractor's QIC.

II-M PAYMENT TO PROVIDERS

The Contractor must make timely payments to all providers for covered services rendered to enrollees as required by MCL 400.111i and in compliance with established DCH performance standards (Appendix 9). 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.

1. Electronic Billing Capacity

   The Contractor must meet the HIPAA and MDCH guidelines and requirement for electronic billing capacity and may require its providers to meet the same standard as a condition for payment. HIPAA guidelines are found at www.michigan.gov/mdch under providers then HIPAA.

   Medicaid policy and provider manuals specify the acceptable coding and procedures. Therefore, a provider must be able to bill a Contractor using the same format and coding instructions as that required for the Medicaid FFS programs. Contractors may not require providers to complete additional fields on the electronic forms that are not specified under the Medicaid FFS policy and provider manuals. Health plans may require additional documentation, such as medical records, to justify the level of care provided. In addition, health plans may require prior authorization for services for which the Medicaid FFS program does not require prior authorization.

   DCH will update the web-site addresses of plans. This information will make it more convenient for providers; (including out of network providers) to be aware of and contact respective health plans regarding the documentation, prior authorization issues, and provider appeal processes. Contractors are responsible for maintaining the completeness and accuracy of their websites regarding this information. The DCH web-site location is: www.michigan.gov\mdch

2. Payment Resolution Process

   The Contractor must develop and maintain an effective provider appeal process to promptly resolve provider billing disputes. The Contractor will cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.

3. Arbitration

   When a provider requests arbitration, the Contractor is required to participate in a binding arbitration process.

   DCH will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will be organizations with the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. A model agreement will be developed by DCH that both parties to the dispute will be required to sign. This agreement will specify the name of the arbitrator, the dispute resolution process, a timeframe for the arbitrator's decision, and the method of payment for the arbitrator's fee.

   The party found to be at fault will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

4. Post-payment Review

   The Contractor may utilize a post-payment review methodology to assure claims have been paid appropriately.

5. Total Payment

   The Contractor or its providers may not require any co-payments, patient-pay amounts, or other cost-sharing arrangements unless authorized by DCH. The Contractor's providers may not bill enrollees for the difference between the provider's charge and the Contractor's payment for covered services. The Contractor's providers will not seek nor accept additional or supplemental payment from the enrollee, his/her family, or representative, in addition to the amount paid by the Contractor even when the enrollee has signed an agreement to do so. These provisions also apply to out-of-network providers.

6. Enrollee Liability for Payment

   The enrollee shall not be held liable for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR 438.116:

   - The Contractors debts, in case of insolvency;
   - Covered services under this Contract provided to the enrollee for which the State did not pay the Contractor;
   - Covered services provided to the enrollee for which the State or the Contractor does not pay the provider due to contractual, referral or other arrangement; or
   - Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

7. Hospital Payments

   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.

II-N PROVIDER SERVICES (In-Network and Out-of-Network)

The Contractor will:

- Provide contract and education services for the provider network
- Properly maintain medical records
- Process provider grievances and complaints in a timely manner
- Develop and maintain an appeal system to resolve claim and authorization disputes
- Maintain a written plan detailing methods of provider recruitment and education regarding Contractor policies and procedures;
- Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, or a regular provider newsletter;
- Provide a staff of sufficient size to respond timely to provider inquiries, questions, and concerns regarding covered services.
- Provide a copy of the Contractor's prior authorization policies to the provider when the provider joins the Contractor's provider network. The Contractor must notify providers of any changes to prior authorization policies as changes are made.

- Make its provider policies, procedures and appeal processes available over its website. Updates to the policies and procedures must be available on the website as well as through other media used by the Contractor.

II-O QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

1. Quality Assessment and Performance Improvement Program (QAPI)

   The Contractor will have an ongoing QAPI program for the services furnished to its enrollees that meets the requirements of 42 CFR 438.240. The Contractor's medical director shall be responsible for managing the QAPI program. The Contractor must maintain a Quality Improvement Committee (QIC) for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including but not limited to the quality improvement director and other key management staff, as well as health professionals providing care to enrollees.

   The Contractor's QAPI program will be capable of identifying opportunities to improve the provision of health care services and the outcomes of such care for enrollees. The Contractor's QAPI program must also incorporate and address findings of site reviews by DCH, external quality reviews, statewide focused studies, and the recommendations of the Clinical Advisory Committee (CAC). In addition, the Contractor's QAPI program must develop or adopt performance improvement goals, objectives, and activities or interventions as required by the DCH to improve service delivery or health outcomes for enrollees.

   The Contractor will have a written plan for the QAPI program that includes, at a minimum, the following:

   - The Contractor's performance goals and objectives
   - Lines of authority and accountability
   - Data responsibilities
   - Evaluation tools
   - Performance improvement activities

   The written plan must also describe how the Contractor will:

   - Analyze the processes and outcomes of care using currently accepted standards from recognized medical authorities. Contractors may include examples of focused review of individual cases, as appropriate.
   - Determine underlying reasons for variations in the provision of care to enrollees.
   - Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement.
   - Use measures to analyze the delivery of services and quality of care, over and under utilization of services, disease management strategies, and outcomes of care. The Contractor is expected to collect and use data from multiple sources such as HEDIS®, medical records, encounter data, claims processing, grievances, utilization review, and member satisfaction instruments in this activity.
   - Compare QAPI program findings with past performance and with established program goals and available external standards.
   - Measure the performance of providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers.
   - At least twice annually, provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor.
   - Develop and/or adopt 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.
   - Ensure that where applicable, utilization management, enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines.

- Evaluate access to care for enrollees according to the established standards and those developed by DCH and Contractor's QIC and implement a process for ensuring that network providers meet and maintain the standards.

  The evaluation should include an analysis of the accessibility of services to enrollees with disabilities.
- Perform a member satisfaction survey according to DCH specifications and distribute results to providers, enrollees, and DCH
- Implement improvement strategies related to program findings and evaluate progress periodically but at least annually.
- Maintain Contractor's written QAPI program that will be available at the annual on-site visit and to DCH upon request.

2. Annual Effectiveness Review

   The Contractor will conduct an annual effectiveness review of its QAPI program. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for enrollees as a result of quality assessment and improvement activities and interventions carried out by the Contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the Contractor's QAPI program must be provided annually to network providers and to enrollees upon request. Information on the effectiveness of the Contractor's QAPI program must be provided to DCH annually during the on-site visit and upon request.

3. Annual Performance Improvement Projects

   The Contractor must conduct performance improvement projects that focus on clinical and non-clinical areas. The Contractor must meet minimum performance objectives. The Contractor may be required to participate in statewide performance improvement projects that cover clinical and non-clinical areas.

   The DCH will collaborate with Stakeholders and Contractors to determine priority areas for statewide performance improvement projects. The priority areas may vary from one year to the next and will reflect the needs of the population; such as care of children, pregnant women, and persons with special health care needs, as defined by DCH. The Contractor will assess performance for the priority area(s) identified by the collaboration of DCH and other Stakeholders.

4. Performance Monitoring

   DCH has established annual performance monitoring standards. The Contractor will incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QAPI program. DCH will use the results of performance assessments as part of the formula for automatic enrollment assignments. DCH will continually monitor Contractor's performance on the performance monitoring standards and make changes as appropriate. The performance monitoring standards are attached to the Contract (Appendix 9)

5. External Quality Review (EQR)

   The State will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the Contractor. The Contractor will address the findings of the external review through its QAPI program. The Contractor must develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of the Contractor's QAPI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the Contractor's QAPI program. DCH may also require separate submission of an improvement plan specific to the findings of the EQR.

6. Consumer Survey

   Contractors must conduct an annual survey of their adult enrollee population using the Consumer Assessment of Health Plan Survey (CAHPS) instrument. Contractors must directly contract with a National Committee for Quality Assurance (NCQA) certified CAHPS vendor and submit the data according to the specifications established by the DCH. The Contractor must provide NCQA summary and member level data to DCH upon request.

II-P UTILIZATION MANAGEMENT

The major components of the Contractor's utilization management program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- The utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.

The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

The Contractor's authorization policy must establish timeframes for standard and expedited authorization decisions. These timeframes may not exceed 14 calendar days for standard authorization decisions and 3 working days 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 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.

II-Q THIRD PARTY RESOURCE REQUIREMENTS

The Contractor will collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D. The Contractor will be responsible for identifying and collecting third party information and may retain third party collections. If third party resources are available, the Contractor is not required to pay the provider first and then recover money from the third party.

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a member's health care coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. The Contractor may retain all such collections. If TPL resources are available, the Contractor is not required to pay the provider first and then recover money from the third party 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.
DCH will provide the Contractor with a listing of known third party resources for its enrollees. The listing will be produced monthly and will contain information made available to the State at the time of eligibility determination and /or redetermination.

When an enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any Contractor. The Contractor must make the Enrollee whole by paying or otherwise covering all Medicare cost sharing amounts incurred by the Enrollee such as coinsurance and deductibles.

II-R MARKETING

With the approval of DCH, contractors are allowed to promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of the entire approved service area.

However, direct marketing to individual beneficiaries or enrollees is prohibited. The Contractor may not provide inducements through which compensation, reward, or supplementary benefits or services are offered to beneficiaries to enroll or to remain enrolled with the Contractor. DCH will review and approve any form of marketing. The following are examples of allowed and prohibited marketing locations and practices:

1. Allowed Marketing Locations/Practices Directed at the General Population:
   - Newspaper articles
   - Newspaper advertisements
   - Magazine advertisements
   - Signs
   - Billboards
   - Pamphlets
   - Brochures
   - Radio advertisements
   - Television advertisements
   - Noncapitated plan sponsored events
   - Public transportation (i.e. buses, taxicabs)
   - Mailings to the general population
   - Individual Contractor “Health Fair” for enrollee members
   - Malls or commercial retail establishments
   - Community centers
   - Churches
2. Prohibited Marketing Locations/Practices that Target Individual Beneficiaries:

   - Local FIA offices
   - Provider offices
   - Hospitals
   - Check cashing establishments
   - Door-to-door marketing
   - Telemarketing
   - Clinics
   - Direct mail targeting individual Medicaid Beneficiaries
   - WIC clinics

3. Marketing Materials

   All written and oral marketing 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.

   Marketing materials must be available in languages appropriate to the beneficiaries being served within the county.

All material must be culturally appropriate and available in alternative formats in accordance with the American with Disabilities Act.
DCH may impose monetary or restricted enrollment sanctions should the Contractor, any of its subcontractors, or contracted providers engage in prohibited marketing practices or use marketing materials that have not been approved in writing by DCH.

Materials must be written at no higher than 6th grade level as determined by any one of the following indices:

- Flesch – Kincaid
- Fry Readability Index
- PROSE The Readability Analyst (software developed by Educational Activities, Inc.)
- Gunning FOG Index
- McLaughlin SMOG Index
- Other computer generated readability indices accepted by DCH

II-S ENROLLEE SERVICES

All written and oral materials directed to enrollees such as handbooks and other member materials must be approved by DCH prior to distribution to enrollees. Upon receipt by DCH of a complete request for approval of the proposed communication, the DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. All enrollee services must address the need for culturally appropriate interventions. Reasonable accommodation must be made for enrollees with hearing and/or vision impairments.

1. General

Contractors will establish and maintain a toll-free 24 hours a day, 7 days a week telephone number to assist enrollees. Direct contact with a qualified clinical staff person or network provider must be available through a toll-free telephone number at all times.

Contractors will issue an eligibility card to all enrollees that includes the toll free 24 hours a day, 7 days a week phone number for enrollees to call and a unique identifying number for the enrollee. The card must also identify the member's PCP name and phone number. Contractors may meet this requirement in one of the following ways:

- Print the PCP name and phone number on the card. The Contractor must send a new card to the enrollee when the PCP assignment changes.
- Print the PCP name and phone number on a replaceable sticker to be attached to the card. The Contractor must send a new sticker to the enrollee when the PCP assignment changes.
- Any other method approved by DCH, provided that the PCP name and phone number is affixed to the card and the information changes when the PCP assignment changes.

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).

Contractors will accept as enrolled all enrollees appearing on monthly enrollment reports and infants enrolled by virtue of the mother's enrollment status. Contractors may not discriminate against beneficiaries on the basis of health needs or health status. Contractors may not encourage an enrollee to disenroll because of health care needs or a change in health care status. Further, an enrollee's health care utilization patterns may not serve as the basis for disenrollment from the Contractor. Subject to the above, Contractors may request that DCH prospectively disenroll an enrollee for cause and present all relevant evidence to assist DCH in reaching its decision.

DCH shall consider all relevant factors in making its decision. DCH's decision regarding disenrollment shall be final. Disenrollments "for cause" will be the first day of the next available month.

2. Enrollee Education

(a) The Contractor will be responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the Contractor's services. Materials for enrollee education should include:

- Member handbook
- Contractor bulletins or newsletters sent to the Contractor's enrollees at least two times a year that provide updates related to covered services, access to providers and updated policies and procedures.
- Literature regarding health/wellness promotion programs offered by the Contractor.
- A website, maintain 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, and updated policies and procedures.

(b) Enrollee education should also focus on the appropriate use of health services. Contractors are encouraged to work with local and community based organizations to facilitate their provision of enrollee education services.

3. Member Handbook/Provider Directory

Contractors must mail the member ID card to enrollees via first class mail within ten (10) business days of being notified of their enrollment. All other printed information, including member handbook, provider directory, and information regarding accessing services may be mailed separately from the ID card. These materials do not have to be mailed via first class but must be mailed within ten business days of being notified of the member's enrollment.

Contractors may select the option of distributing new member packets to each household, instead of to each individual member in the household, provided that the mailing includes individual Health Plan membership cards for each member enrolled in the household. When there are program or service site changes, notification must be provided to the affected enrollees at least ten (10) business days before implementation.

The Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least once a year and updated when necessary. The provider directory may be published separately. At a minimum, the member handbook must include the following information:

- Table of contents
- Advance directives, including, at a minimum: (1) information about the Contractor's advance directives policy, (2) information regarding the State's advance directives provisions and (3) directions on how to file a complaint with the State concerning noncompliance with the advance directive requirements. Any changes in the State law must be updated in this written information no later than 90 days following the effective date of the change.
- Availability and process for accessing covered services that are not the responsibility of the Contractor, but are available to its enrollees such as dental care, behavioral health and developmental disability services
- Description of all available Contract services
- Designation of specialists as a PCP
- Enrollees' rights and responsibilities. The enrollee rights information must include a statement that conveys that Contractor staff and affiliated providers will comply with all requirements concerning enrollee rights.

- Enrollees' right to obtain routine OB/GYN and Pediatric services from network providers without a referral.
- Enrollees' right to receive FQHC services
- Enrollees' right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, whether stop-loss coverage is provided
- Explanation of any service limitations or exclusions from coverage
- Grievance and appeal process including how to register a grievance with the Contractor and/or State, how to file a written appeal, and the deadlines for filing an appeal and an expedited appeal
- How enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior
- How to access hospice services
- How to choose and change PCPs
- How to contact the Contractor's Member Services and a description of its function
- How to handle out of county and out of state services
- How to make, change, and cancel appointments with a PCP
- How to obtain emergency transportation and medically necessary transportation
- How to obtain medically necessary durable medical equipment (or customized durable medical equipment)
- How to obtain oral interpretation services and written information in prevalent languages, as defined by the Contract.
- How to obtain written materials in alternative formats for enrollees with special needs.
- Pregnancy care information that conveys the importance of prenatal care and continuity of care, to promote optimum care for mother and infant
- Process of referral to specialists and other providers
- Signs of substance abuse problems, available substance abuse services and accessing substance abuse services
- State Fair Hearing process including that access may occur without first going through the Contractor's grievance/complaint process
- Vision services, family planning services, and how to access these services
- Well-child care, immunizations, and follow-up services for enrollees under age 21 (EPSDT)
- What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations
- What to do when family size changes
- Women's, Infant's, and Children (WIC) Supplemental Food and Nutrition Program
- Any other information deemed essential by the Contractor and/or the DCH

The handbook must be written at no higher than a sixth 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 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.

The Contractor must maintain a provider directory that contains, at a minimum, the following information:

- PCPs and specialists listed by county.
- 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.
- For Specialist listings, the following information must be provided: Provider name, address, telephone number, and any hospital affiliation.

- A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers the enrollees may need to access. The list must contain the address and phone number of the provider. Ancillary providers that are part of a retail chain may be listed by the name of the chain without listing each specific site.

4. Protection of Enrollees against Liability for Payment and Balanced Billing

   Section 1932(b)(6) of the Social Security Act requires Contractors to protect enrollees from certain payment liabilities. Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to providers in the case of services provided to an individual enrolled with a Contractor that are charges at a rate in excess of the rate permitted under the organization's Contract.

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) The Contractor shall administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and MCL 550.1404 and 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."

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

   - The Contractor must give enrollees reasonable 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:
     (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

2. Notice to Enrollees of Grievance Procedure

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

   - How to file a grievance with the Contractor
   - The internal grievance resolution process

3. Notice to Enrollees of Appeal Procedure

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

- How to file an appeal with the Contractor
- The internal appeal process
- The member's right to a Fair Hearing with the State

When the Contractor makes a decision subject to appeal, as defined in this contract, the Contractor must provide a written adverse action notice to the enrollee and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services must be made at least ten (10) days prior to the change in services. Adverse action notices involving service authorization decisions that deny or limit services must be made within the time frames described in Section II-P of this Contract. The notice must include the following components:

- The action the Contractor or subcontractor has taken or intends to take;
- The reasons for the action;
- The enrollee's or provider's right to file an appeal;
- An explanation of the Contractor's appeal process;
- The enrollee's right to request a Medicaid Fair Hearing;
- The circumstances under which expedited resolution is available and how to request it; and
- The enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

4. State Medicaid Appeal Process

The State will maintain a Medicaid Fair Hearing process to ensure that enrollees have the opportunity to appeal decisions directly to the State. The Contractor must include the Medicaid Fair Hearing process as part of the written internal process for resolution of appeals and must describe the Medicaid Fair Hearing process in the Member Handbook.

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 days of the adverse determination.
- The Contractor will make a decision on the expedited appeal within 3 working days of receipt of the expedited appeal. This timeframe may be extended up to 10 calendar 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 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.

II-U CONTRACTOR ON-SITE REVIEWS

Contractor on-site reviews by DCH will be an ongoing activity conducted during the Contract. The Contractor's on-site review may include the following areas: administrative, provider network capacity and services, member services, quality assurance, utilization review, data reporting, claims processing, fraud and abuse, and documentation. The DCH shall establish findings of pass, incomplete, fail, or deemed status for each criteria included in the annual site visit and tool used to assess health plan compliance. Deemed status is granted when a DCH approved accrediting agency has reviewed the criteria and determined that the plan meets the criteria. When deemed status is granted, that specific criterion is not reviewed by DCH.

II-V CONTRACT REMEDIES AND SANCTIONS

The State will utilize a variety of means to assure compliance with Contract requirements. The State will pursue remedial actions or improvement plans that the Contractor can implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented. DCH may employ contract remedies and/or sanctions to address any Contractor noncompliance with the Contract; this includes, but is not limited to, noncompliance with Contract requirements on the following issues:

- Marketing practices
- Member services
- Provision of medically necessary, covered services
- Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services
- Provider networks
- Provider payments
- Financial requirements, including but not limited to failure to comply with physician incentive plan requirements
- Enrollee satisfaction
- Performance standards included at Appendix 9 to the Contract
- Misrepresentation or false information provided to DCH, CMS, providers, enrollees, or potential enrollees

DCH may utilize intermediate sanctions (as described in 42.438.700) that may include suspension of enrollment and/or payment. Intermediate sanctions may also include the appointment of temporary management, as provided in 42 CFR 438.706. If a temporary management sanction is imposed, DCH will work concurrently with the Office of Financial and Insurance Services.

If intermediate sanctions or general remedies are not successful or DCH determines that immediate termination of the Contract is appropriate, as allowed by Section I-S, the State may terminate the Contract with the Contractor. The Contractor must be afforded a hearing before termination of a Contract under this section can occur. The State must notify enrollees of such a hearing and allow enrollees to disenroll, without cause, if they choose. In addition to the sanctions described above, DCH will administer and enforce a monetary penalty of not more than $5000.00 to a Contractor for each repeated failure on any of the findings of DCH site visit report. Collections of Contract sanctions will be through gross adjustments to the monthly payments described in ITB Section II-Z of this Contract and will be allocated to the fund established under ITB Section II-Z-1 of the Contract for performance bonus.

II-W DATA REPORTING

To measure the Contractor's accomplishments in the areas of access to care, utilization, medical outcomes, enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates the Contractor must provide the DCH with uniform data and information as specified by DCH. The Contractor must submit an annual consolidated report using the instructions and format covered in Contract Appendix 4.

As part of the annual consolidated report, Contractors must submit annual litigation reports in a format established by DCH, providing the following detail for all civil litigation that the Contractor, subcontractor, or the Contractor's insurers or insurance agents are parties to:

Court or Jurisdiction where the complaint was filed and docket number
Name of plaintiff(s) and defendant(s)
Names and addresses of all counsel appearing
Nature of the claim
Status of the case

Also as part of the annual consolidated report, the Contractor's CEO must submit a DCH Data Certification form to DCH that requires the Contractor to attest to the accuracy, completeness, and truthfulness of any and all data and documents submitted to the State as required by the Contract. When the health plan employs a new CEO, a new DCH Data Certification form must be submitted to DCH within 15 days of the employment date.

Also, as part of the annual consolidated report, the Contractor must perform and document an annual assessment of their QAPI program. This assessment should include a description of any program completed and all ongoing QI activities for the applicable year, an evaluation of the overall effectiveness of the program, and an annual work plan. DCH may also request other reports or improvement plans addressing specific contract performance issues identified through site visit reviews, EQRs, focused studies, or other monitoring activities conducted by DCH.

The Contractor must cooperate with DCH in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols. The Contractor must develop and implement corrective action plans to correct data validity problems as identified by the DCH.

In addition to the annual consolidated report, the Contractor must submit the following additional reports as specified in this section. Any changes in the reporting requirements will be communicated to the Contractor at least sixty (60) days before they are effective unless state or federal law requires otherwise.

1. HEDIS® Submission

   The Contractor must annually submit a Medicaid-product HEDIS® report according to the most current NCQA specifications and timelines. The Contractor must contract with a NCQA certified HEDIS® vendor and undergo a full audit of their HEDIS® reporting process.

2. Encounter Data Submission

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

   Submitted encounter data will be subject to quality data edits prior to acceptance into DCH's data warehouse. Stored encounter data will be subject to regular and ongoing quality checks as developed by DCH. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by DCH (See Appendix 9). The Contractor must participate in regular data quality assessments conducted as a component of ongoing encounter data on-site activity.

3. Financial and Claims Reporting

   In addition to meeting all HMO financial reporting requirements and providing copies of the HMO financial reports to DCH, Contractors must provide to DCH monthly statements that provide information regarding paid claims, aging of unpaid claims,

and denied claims in the format specified by DCH. The DCH may also require monthly financial statements from Contractors.

4. Semi-annual Grievance and Appeal Report

   The Contractor must track the number and type of grievances and appeals. This information must be summarized by the level at which the grievance or appeal was resolved.

II-X RELEASE OF REPORT DATA

The Contractor must obtain DCH's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its enrollees other than as required by this contract, statute or regulations.

II-Y MEDICAL RECORDS

The Contractor must ensure that its providers maintain medical records of all medical services received by the enrollee. The medical record must include, at a minimum, a record of outpatient and emergency care, specialist referrals, ancillary care, diagnostic test findings including all laboratory and radiology, prescriptions for medications, inpatient discharge summaries, histories and physicals, immunization records, other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

1. Medical Record Maintenance

   The Contractor’s medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be signed and dated. All medical records must be retained for at least six (6) years.

   The Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. The Contractor must have written plans for providing training and evaluating providers' compliance with the recognized medical records standards.

2. Medical Record Confidentiality/Access

   The Contractor must have written policies and procedures to maintain the confidentiality of all medical records. The Contractor must comply with applicable State and Federal laws regarding privacy and securing of medical records and protected health information.

   DCH and/or CMS shall be afforded prompt access to all enrollees' medical records. Neither CMS nor DCH are required to obtain written approval from an enrollee before requesting an enrollee's medical record. When an enrollee changes PCP, the former PCP must forward his or her medical records or copies of medical records to the new PCP within ten (10) working days from receipt of a written request.

II-Z PAYMENT PROVISIONS

Payment under this contract will consist of a fixed reimbursement plan with specific monthly payments. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. The price per covered member will be risk adjusted (i.e., it will vary for different categories of enrollees). For enrollees in the TANF program categories, the risk adjustment will be based on age and gender. For enrollees in the Blind and Disabled program category, Michigan will utilize the Chronic Illness and Disability Payment System (CDPS) to adjust the capitation rates paid to the Contractor.

Under CDPS, diagnosis coding as reported on claim and encounter transactions are used to compute a score for each individual. Individuals with inadequate eligibility history will be excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case-mix value for each Contractor based on its enrolled population. The regional rate for the Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each MCO. The aggregate impact will be budget or rate neutral. MDCH will fully re-base the risk adjustment system annually. A limited adjustment to the case mix adjusted rates will occur in the intervening 6-month intervals based only on Contractor enrollment shifts.

DCH will review changes in implemented Medicaid policy to determine the financial impact on the CHCP. If DCH determines that the policy changes significantly affect the overall cost to the CHCP, DCH will adjust the fixed price per covered member to maintain the actuarial soundness of the rates.

DCH will generate HIPAA compliant 834 files that will be sent to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, DCH will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month and DCH will report payments to Contractors on a HIPAA compliant 820 file. A process will be in place to ensure timely payments and to identify enrollees that the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns).

The application of Contract remedies and performance bonus payments as described in Section II of this Contract will affect the lump sum payment. Payments in any given fiscal year are contingent upon and subject to federal and state appropriations.

1. Contractor Performance Bonus

   During each Contract year, DCH will withhold .0025 of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

II-AA RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH

DCH will administer the CHCP, monitor Contractor performance, and conduct the following specific activities:

- Pay to the Contractor a PMPM Capitation Rate as agreed to in the Contract for each enrollee. DCH will also pay a maternity case rate payment to the Contractor for AFDC program enrollees who give birth while enrolled in the Contractor's plan.
- Determine eligibility for the Medicaid program and determine which beneficiaries will be enrolled.
- Determine if and when an enrollee will be disenrolled from the Contractor's plan or changed to another Medicaid managed care program.
- Notify the Contractor of changes in enrollment.
- Notify the Contractor of the enrollee's name, address, and telephone number if available. The Contractor will be notified of changes as they are known to the DCH.
- Issue Medicaid identification cards (mihealth card) to enrollees.
- Provide the Contractor with information related to known third party resources and any subsequent changes and be responsible for reporting paternity related expenses to FIA.
- Notify the Contractor of changes in covered services or conditions of providing covered services.
- Maintain a Clinical Advisory Committee to collaborate with Contractors on quality improvement.
- Administer a Medicaid Fair Hearing process consistent with federal requirements.

- Collaborate with the Contractor on quality improvement activities, fraud and abuse issues, and other activities which impact on the health care provided to enrollees.
- Conduct a member satisfaction survey of child enrollees, and compile, and publish the results.
- Review and approve all Contractor marketing and member information materials prior to distribution to enrollees.
- Apply Contract remedies and sanctions as necessary to assure compliance with Contract requirements.
- Monitor the operation of the Contractor to ensure access to quality care for enrollees.
- Provide timely data to Contractors at least 30 days before the effective date of FFS pricing or coding changes or DRG changes.
- Implement mechanisms to identify persons with special health care needs.
- Assess the quality and appropriateness of care and services furnished to all of Contractor's Medicaid enrollees and individuals with special health care needs utilizing information from required reports, on-site reviews, or other methods DCH determines appropriate.
- Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. (State must provide this information to the Contractor at the time of enrollment).
- Regularly monitor and evaluate the Contractor's compliance with the standards.
- Protect against fraud and abuse involving Medicaid funds and enrollees in cooperation with appropriate state and federal authorities.
- Make all fraud and/or abuse referrals to the office of Attorney General, Health Care Fraud Division.

II-BB MEMORANDUM OF AGREEMENT WITH DETROIT HEALTH AUTHORITY (DWCHA)

Contractors approved under this contract to operate in Wayne County will establish a standard memorandum of agreement (MOA) with the Detroit/Wayne County Health Authority within 3 months after the development of a Model MOA. The MOA 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.

LIST OF APPENDICES

Appendix 1: **Rural Exception Counties**

Appendix 2: **Financial Monitoring Standards**

Appendix 3: **Health Plan Reporting Schedule**

Appendix 4: **Performance Monitoring Standards**

Appendix 5: **Performance Bonus Template**

LIST OF ATTACHMENTS

Attachment A: **Per Member Per Month Capitated Rates by Region by County**

Attachment B: **Approved Service Area by Region by County**

Appendix 1

Rural Exception Counties

The following are counties qualified for the Rural Area Exception. Implementation of the Rural Area Exception in any county will be determined by DCH with approval from CMS.

Alcona	Keweenaw
Alger	Luce
Alpena	Mackinac
Arenac	Manistee
Baraga	Marquette
Bay	Menominee
Benzie	Midland
Chippewa	Missaukee
Clare	Montmorency
Crawford	Ogemaw
Delta	Ontonagon
Dickinson	Oscoda
Gladwin	Otsego
Gogebic	Presque Isle
Gratiot	Roscommon
Houghton	Saginaw
Huron	Sanilac
Iosco	Schoolcraft
Iron	Tuscola
Isabella	Wexford

Appendix 2

MDCH Financial Monitoring Standards

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

Appendix 3
2004 Reporting Requirements for Medicaid Health Plans

Report	Due Date[3]	Period Covered	Instructions/Format
ANNUAL			
Consolidated Annual Report[1]	3/1/04	1/1/03 - 12/31/03	Contract Appendix 4
Audited Financial Statements	6/1/04	1/1/03 - 12/31/03	NAIC, OFIS
HEDIS DST [2]	6/30/04	1/1/03 - 12/31/03	NCQA- 2 hard copies and 2 electronic copies
HEDIS Compliance Audit Report	7/30/04	1/1/03 - 12/31/03	NCQA
QIP Annual Evaluation and Work Plan*	7/30/04	Current Approved Evaluation and Work Plan*	Contract II-O
SEMI-ANNUAL			
Complaint and Grievance	1/30/04 7/30/04	7/1/03 - 12/31/03 1/1/04 - 6/30/04	MSA 131
QUARTERLY			
Financial	5/15/04 8/15/04 11/15/04	1/1/04 - 3/31/04 4/1/04 - 6/30/04 7/1/03 - September 30, 2004	NAIC OFIS
Third Party Collection	5/15/04 8/15/04 11/15/04	1/1/04 - 3/31/04 4/1/04 - 6/30/04 7/1/03 - September 30, 2004	Report on separate sheet and send with NAIC
MONTHLY			
Claims Processing	30 days after end of month *NOT last day of month*	•Data covers previous month •i.e., data for 2/04 due by 3/30/04	MSA 2009(E) Revised 9/03
Encounter Data	The 15th of each month	•Minimum of Monthly •Data covers previous month •i.e., data for 1/04 due by 2/15/04	Encounter Data Submission Manual

1. Annual Report Components
   - Health Plan Profile (MSA 126) NOTE: Include a list of Governing Body Members
   - Financial (NAIC, all reports required by OFIS, and Statement of Actuarial Opinion are due with the annual report on 3/1/04). NOTE: The Management Discussion and Analysis is due 4/1/04 and the Audited Financial Statements are due 6/1/04.
   - Health Plan Data Certification Form (MSA 2012)
   - Litigation (limited to litigation directly naming health plan, MSA 129)
   - Physician Incentive Program (PIP) Reporting (CMS annual update form
   - Medicaid Provider Directory
   - Medicaid Certificate of Coverage
   - Medicaid Member Handbook
2. Due on 6/30/03: HEDIS DST and signed and dated Attestation of Accuracy and Public Reporting Authorization (Medicaid letter from NCQA). Due on 7/30/03: HEDIS Compliance Audit Report and certified auditor's signed and dated Final Audit Statement. Please refer to HEDIS Policy - MHP 02-03 issued 03-01-02 for detailed instructions.
3. If due date is not a business day, reports received on the next business day will be considered timely.
4. *NOTE: New requirement for 2004

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 intended to be part of the Contract between the State of Michigan and Contracting Health Plans (Appendix 4).

The process is intended to be dynamic and reflect state and national issues that may change on a year to year basis. Performance measurement will be shared with Health Plans during the fiscal year and will compare 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
- Encounter Data
- Provider File reporting
- Claims Reporting and Processing

For each performance measure the following categories will be identified:

- 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
• **Quality of Care:** Childhood Immunization Status	**Fully immunize children who turn two years old during the calendar year.**	**Combination 1 ≥ 65%**	HEDIS report	Annual
• **Quality of Care:** Prenatal Care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	**≥ 65%**	HEDIS report	Annual
• **Quality of Care:** Blood Lead Testing	Children at the age of 3 years that have had at least one blood lead test on/before 3rd birthday	**≥ 50%**	Blood Lead Registry	Quarterly
• **Access to care:** Well-Child Visits in the First 15 Months of Life	Children 15 months of age receive one or more well child visits during first 15 months of life	**≥ 90%**	Encounter data	Quarterly (rolling 12 months)
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six old receive one or more well child visits during twelve-month period.	**≥ 45%**	Encounter data	Quarterly (rolling 12 months)
• **Customer Services:** Enrollee Complaints	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	**Complaint rate < 5 per 1000 member months**	Beneficiary/ Provider complaint tracking (BPCT)	Quarterly
• **Claims Reporting and Processing**	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	**Timely, ≥90% of clean claims paid within 30 days, and ≤2% of ending inventory over 45 days old**	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting**	Timely and complete encounter data submission by the 15th of the month	**Timely and Complete submission**	MDCH Data Exchange Gateway (DEG)	Monthly

PERFORMANCE AREA	**GOAL**	**MINIMUM STANDARD**	**DATA SOURCE**	**MONITORING INTERVALS**
• **Provider File Reporting**	Timely provider file update/submission before the last Tuesday of the month	**Timely and Complete submission**	MI Enrolls	Monthly

Appendix 5
Performance Bonus Template

Health Plan Name - Template	FY 04 Performance Bonus Template		2003 NCQA Medicaid Percentiles		
Clinical Measures - 2004 HEDIS	**2003 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**Median**	**75%**	**90%**
Women's Care					
Breast Cancer		0	56.0%	62.3%	67.0%
Cervical Cancer		0	62.7%	73.7%	77.9%
Chlamydia - Combined Rate		0	42.0%	49.0%	59.6%
Prenatal Care		0	74.3%	85.1%	89.1%
Postpartum Care		0	54.8%	61.7%	67.2%
Living with Illness					
Diabetes Care					
HgA1C test		0	77.4%	84.2%	88.0%
LDL-C Screening		0	74.7%	80.6%	85.2%
Eye exam		0	49.2%	58.2%	63.7%
Appropriate Asthma Meds - Combined		0	63.8%	68.1%	70.9%
Advising Smokers to Quit		0	64.1%	66.7%	70.9%
Pediatric Care					
Well Child Visits					
0-15 Months - 0 visits		0	3.0%	1.7%	0.7%
0-15 Months - 6+ visits		0	43.5%	54.5%	62.0%
3-6 Years		0	59.9%	67.3%	73.1%
Adolescent		0	37.2%	44.0%	50.3%
Immunizations					
Childhood - Combo 1		0	59.6%	68.6%	75.9%
Childhood - Combo 2		0	56.3%	63.1%	70.0%
Adolescent - Combo 1		0	41.6%	55.5%	69.3%
Access to Care - 2004 HEDIS					
Children	**2003 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**Median**	**75%**	**90%**
12-24 Months		0	93.5%	96.3%	97.4%
25 Months - 6 Years		0	83.2%	86.7%	89.3%
7-11 Years		0	82.6%	86.7%	89.8%
Adult					
20-44 Years		0	77.9%	83.2%	86.7%
45-64 Years		0	84.2%	87.8%	89.7%
Survey Measures - CAHPS		**Average (1 point); Above Average (3 points)**	**Average****	**Above Average*****	

Getting Needed Care - Adult		0			
Getting Care Quickly - Adult		0			
Getting Needed Care - Child		0			
Getting Care Quickly - Child		0			
		Average (2 points); Above Average (5 points)	**Average****	**Above Average*****	
Health Plan Rating - Adult		0			
Health Plan Rating - Child		0			
Accreditation Status - 2003	**Accredited or Accreditation with Requirement for Improvement (7 pts) as of 12/31/03**		**NCQA or JCAHO New Plan Accreditation as of 12/31/03 (8.5 points)**	**Excellent/ Commendable or Full Accreditation (10 Pts) as of 12/31/03**	
NCQA or JCAHO (Date)					
Total Member Months of Enrollment by Age and Sex - HEDIS 2004					
	Possible Points	**Health Plan Points**	**Legislative Incentive Requirements**	**2004 HEDIS Score**	**Eligible for Incentive**
Clinical Measures (42.50%)	68	0	Adolescent - Combo 1 (40%)	0.0%	0
Access to Care (12.50%)	20	0	Adolescent Well Care (37%)	0.0%	0
Survey Measures (CAHPS) (13.75%)	22	0	Prenatal Care (75%)	0.0%	0
Accreditation Status (6.25%)	10	0.0	Postpartum Care (55%)	0.0%	0
Legislative Incentive Requirements (25.00%)	40	0	**CAHPS Survey Measures**		
Performance Bonus Total Score	**160**	**0**	**** 2 Stars = Statistically Average** ***** 3 Stars = Statistically Higher than Average**		

ATTACHEMENT A

CONTRACTOR'S AWARDED RATES

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 01

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	175.02	0.9642	1.008			170.10	(.43)	169.67
2	TANF	< 1		Female	162.48	0.9642	1.008			157.92	(.39)	157.53
3	TANF	1 - 4		Male	79.46	0.9642	1.008			77.23	(.19)	77.04
4	TANF	1 - 4		Female	65.70	0.9642	1.008			63.85	(.16)	63.69
5	TANF	5 - 14		Male	60.04	0.9642	1.008			58.35	(.15)	58.20
6	TANF	5 - 14		Female	51.99	0.9642	1.008			50.53	(.13)	50.40
7	TANF	15 - 20		Male	70.34	0.9642	1.008			68.36	(.17)	68.19
8	TANF	15 - 20		Female	99.88	0.9642	1.008			97.07	(.24)	96.83
9	TANF	21 - 25		Male	91.27	0.9642	1.008			88.71	(.22)	88.49
10	TANF	21 - 25		Female	153.09	0.9642	1.008			148.79	(.37)	148.42
11	TANF	26 - 44		Male	205.51	0.9642	1.008			199.74	(.50)	199.24
12	TANF	26 - 44		Female	196.95	0.9642	1.008			191.42	(.48)	190.94
13	TANF	45 +		Male	516.46	0.9642	1.008			501.95	(1.25)	500.70
14	TANF	45 +		Female	375.98	0.9642	1.008			365.42	(.91)	364.51
15	ABAD	0 - 20		Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
16	ABAD	0 - 20		Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
17.1	ABAD	21 - 39	Medicare	Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
18.1	ABAD	21 - 39	Medicare	Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
17.2	ABAD	21 - 39		Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
18.2	ABAD	21 - 39		Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
19.1	ABAD	40 - 64	Medicare	Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
20.1	ABAD	40 - 64	Medicare	Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
19.2	ABAD	40 - 64		Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
20.2	ABAD	40 - 64		Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
21.1	ABAD	65 +	Medicare	Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
22.1	ABAD	65 +	Medicare	Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
21.2	ABAD	65 +		Male	673.56	0.9642		1.1048		717.51	(1.79)	715.72
22.2	ABAD	65 +		Female	673.56	0.9642		1.1048		717.51	(1.79)	715.72
23.1	OAA	0 +	Medicare	Male	510.56	0.9642		1.1048	0.758	412.26	(1.03)	411.23
24.1	OAA	0 +	Medicare	Female	510.56	0.9642		1.1048	0.758	412.26	(1.03)	411.23
23.2	OAA	0 +		Male	510.56	0.9642		1.1048	0.758	412.26	(1.03)	411.23
24.2	OAA	0 +		Female	510.56	0.9642		1.1048	0.758	412.26	(1.03)	411.23
Maternity Case Rate:					**3,600.76**	0.9642	1.008			3,499.63	(8.75)	3,490.88

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 02

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	207.78	0.9642	1.055			211.36	(.53)	210.83
2	TANF	< 1		Female	179.67	0.9642	1.055			182.77	(.46)	182.31
3	TANF	1 - 4		Male	74.61	0.9642	1.055			75.90	(.19)	75.71
4	TANF	1 - 4		Female	62.68	0.9642	1.055			63.76	(.16)	63.60
5	TANF	5 - 14		Male	58.09	0.9642	1.055			59.09	(.15)	58.94
6	TANF	5 - 14		Female	50.38	0.9642	1.055			51.25	(.13)	51.12
7	TANF	15 - 20		Male	68.90	0.9642	1.055			70.09	(.18)	69.91
8	TANF	15 - 20		Female	103.85	0.9642	1.055			105.64	(.26)	105.38
9	TANF	21 - 25		Male	96.40	0.9642	1.055			98.06	(.25)	97.81
10	TANF	21 - 25		Female	168.21	0.9642	1.055			171.11	(.43)	170.68
11	TANF	26 - 44		Male	209.91	0.9642	1.055			213.53	(.53)	213.00
12	TANF	26 - 44		Female	228.98	0.9642	1.055			232.93	(.58)	232.35
13	TANF	45 +		Male	455.06	0.9642	1.055			462.90	(1.16)	461.74
14	TANF	45 +		Female	477.73	0.9642	1.055			485.96	(1.21)	484.75
15	ABAD	0 - 20		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
16	ABAD	0 - 20		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
17.1	ABAD	21 - 39	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
18.1	ABAD	21 - 39	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
17.2	ABAD	21 - 39		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
18.2	ABAD	21 - 39		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
19.1	ABAD	40 - 64	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
20.1	ABAD	40 - 64	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
19.2	ABAD	40 - 64		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
20.2	ABAD	40 - 64		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
21.1	ABAD	65 +	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
22.1	ABAD	65 +	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
21.2	ABAD	65 +		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
22.2	ABAD	65 +		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
23.1	OAA	0 +	Medicare	Male	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
24.1	OAA	0 +	Medicare	Female	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
23.2	OAA	0 +		Male	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
24.2	OAA	0 +		Female	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
Maternity Case Rate:					**3,639.70**	0.9642	1.055			3,702.42	(9.26)	3,693.16

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 03

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	207.78	0.9642	0.975			195.33	(.49)	194.84
2	TANF	< 1		Female	179.67	0.9642	0.975			168.91	(.42)	168.49
3	TANF	1 - 4		Male	74.61	0.9642	0.975			70.14	(.18)	69.96
4	TANF	1 - 4		Female	62.68	0.9642	0.975			58.93	(.15)	58.78
5	TANF	5 - 14		Male	58.09	0.9642	0.975			54.61	(.14)	54.47
6	TANF	5 - 14		Female	50.38	0.9642	0.975			47.36	(.12)	47.24
7	TANF	15 - 20		Male	68.90	0.9642	0.975			64.77	(.16)	64.61
8	TANF	15 - 20		Female	103.85	0.9642	0.975			97.63	(.24)	97.39
9	TANF	21 - 25		Male	96.40	0.9642	0.975			90.63	(.23)	90.40
10	TANF	21 - 25		Female	168.21	0.9642	0.975			158.13	(.40)	157.73
11	TANF	26 - 44		Male	209.91	0.9642	0.975			197.34	(.49)	196.85
12	TANF	26 - 44		Female	228.98	0.9642	0.975			215.26	(.54)	214.72
13	TANF	45 +		Male	455.06	0.9642	0.975			427.80	(1.07)	426.73
14	TANF	45 +		Female	477.73	0.9642	0.975			449.11	(1.12)	447.99
15	ABAD	0 - 20		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
16	ABAD	0 - 20		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
17.1	ABAD	21 - 39	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
18.1	ABAD	21 - 39	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
17.2	ABAD	21 - 39		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
18.2	ABAD	21 - 39		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
19.1	ABAD	40 - 64	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
20.1	ABAD	40 - 64	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
19.2	ABAD	40 - 64		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
20.2	ABAD	40 - 64		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
21.1	ABAD	65 +	Medicare	Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
22.1	ABAD	65 +	Medicare	Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
21.2	ABAD	65 +		Male	580.20	0.9642		0.8944		500.35	(1.25)	499.10
22.2	ABAD	65 +		Female	580.20	0.9642		0.8944		500.35	(1.25)	499.10
23.1	OAA	0 +	Medicare	Male	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
24.1	OAA	0 +	Medicare	Female	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
23.2	OAA	0 +		Male	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
24.2	OAA	0 +		Female	492.01	0.9642		0.8944	0.848	359.81	(.90)	358.91
Maternity Case Rate:					**3,639.70**	0.9642	0.975			3,421.66	(8.55)	3,413.11

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 07

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	207.78	0.9642	1.001			200.54	(.50)	200.04
2	TANF	< 1		Female	179.67	0.9642	1.001			173.41	(.43)	172.98
3	TANF	1 - 4		Male	74.61	0.9642	1.001			72.01	(.18)	71.83
4	TANF	1 - 4		Female	62.68	0.9642	1.001			60.50	(.15)	60.35
5	TANF	5 - 14		Male	58.09	0.9642	1.001			56.07	(.14)	55.93
6	TANF	5 - 14		Female	50.38	0.9642	1.001			48.62	(.12)	48.50
7	TANF	15 - 20		Male	68.90	0.9642	1.001			66.50	(.17)	66.33
8	TANF	15 - 20		Female	103.85	0.9642	1.001			100.23	(.25)	99.98
9	TANF	21 - 25		Male	96.40	0.9642	1.001			93.04	(.23)	92.81
10	TANF	21 - 25		Female	168.21	0.9642	1.001			162.35	(.41)	161.94
11	TANF	26 - 44		Male	209.91	0.9642	1.001			202.60	(.51)	202.09
12	TANF	26 - 44		Female	228.98	0.9642	1.001			221.00	(.55)	220.45
13	TANF	45 +		Male	455.06	0.9642	1.001			439.21	(1.10)	438.11
14	TANF	45 +		Female	477.73	0.9642	1.001			461.09	(1.15)	459.94
15	ABAD	0 - 20		Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
16	ABAD	0 - 20		Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
17.1	ABAD	21 - 39	Medicare	Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
18.1	ABAD	21 - 39	Medicare	Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
17.2	ABAD	21 - 39		Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
18.2	ABAD	21 - 39		Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
19.1	ABAD	40 - 64	Medicare	Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
20.1	ABAD	40 - 64	Medicare	Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
19.2	ABAD	40 - 64		Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
20.2	ABAD	40 - 64		Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
21.1	ABAD	65 +	Medicare	Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
22.1	ABAD	65 +	Medicare	Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
21.2	ABAD	65 +		Male	580.20	0.9642		1.0076		563.68	(1.41)	562.27
22.2	ABAD	65 +		Female	580.20	0.9642		1.0076		563.68	(1.41)	562.27
23.1	OAA	0 +	Medicare	Male	492.01	0.9642		1.0076	0.848	405.35	(1.01)	404.34
24.1	OAA	0 +	Medicare	Female	492.01	0.9642		1.0076	0.848	405.35	(1.01)	404.34
23.2	OAA	0 +		Male	492.01	0.9642		1.0076	0.848	405.35	(1.01)	404.34
24.2	OAA	0 +		Female	492.01	0.9642		1.0076	0.848	405.35	(1.01)	404.34
Maternity Case Rate:					**3,639.70**	0.9642	1.001			3,512.91	(8.78)	3,504.13

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 09

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	175.02	0.9642	0.985			166.22	(.42)	165.80
2	TANF	< 1		Female	162.48	0.9642	0.985			154.31	(.39)	153.92
3	TANF	1 - 4		Male	79.46	0.9642	0.985			75.47	(.19)	75.28
4	TANF	1 - 4		Female	65.70	0.9642	0.985			62.40	(.16)	62.24
5	TANF	5 - 14		Male	60.04	0.9642	0.985			57.02	(.14)	56.88
6	TANF	5 - 14		Female	51.99	0.9642	0.985			49.38	(.12)	49.26
7	TANF	15 - 20		Male	70.34	0.9642	0.985			66.80	(.17)	66.63
8	TANF	15 - 20		Female	99.88	0.9642	0.985			94.86	(.24)	94.62
9	TANF	21 - 25		Male	91.27	0.9642	0.985			86.68	(.22)	86.46
10	TANF	21 - 25		Female	153.09	0.9642	0.985			145.40	(.36)	145.04
11	TANF	26 - 44		Male	205.51	0.9642	0.985			195.18	(.49)	194.69
12	TANF	26 - 44		Female	196.95	0.9642	0.985			187.05	(.47)	186.58
13	TANF	45 +		Male	516.46	0.9642	0.985			490.50	(1.23)	489.27
14	TANF	45 +		Female	375.98	0.9642	0.985			357.08	(.89)	356.19
15	ABAD	0 - 20		Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
16	ABAD	0 - 20		Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
17.1	ABAD	21 - 39	Medicare	Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
18.1	ABAD	21 - 39	Medicare	Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
17.2	ABAD	21 - 39		Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
18.2	ABAD	21 - 39		Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
19.1	ABAD	40 - 64	Medicare	Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
20.1	ABAD	40 - 64	Medicare	Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
19.2	ABAD	40 - 64		Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
20.2	ABAD	40 - 64		Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
21.1	ABAD	65 +	Medicare	Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
22.1	ABAD	65 +	Medicare	Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
21.2	ABAD	65 +		Male	673.56	0.9642		1.0655		691.99	(1.73)	690.26
22.2	ABAD	65 +		Female	673.56	0.9642		1.0655		691.99	(1.73)	690.26
23.1	OAA	0 +	Medicare	Male	510.56	0.9642		1.0655	0.758	397.59	(.99)	396.60
24.1	OAA	0 +	Medicare	Female	510.56	0.9642		1.0655	0.758	397.59	(.99)	396.60
23.2	OAA	0 +		Male	510.56	0.9642		1.0655	0.758	397.59	(.99)	396.60
24.2	OAA	0 +		Female	510.56	0.9642		1.0655	0.758	397.59	(.99)	396.60
Maternity Case Rate:					**3,600.76**	0.9642	0.985			3,419.78	(8.55)	3,411.23

State of Michigan Managed Care Rates
Effective October 1, 2004

Great Lakes Health Plan
Region 10

Rate Cell	Description			Gender	Base Rate	Prem Dist FY 05	Area Factor	Risk Adj.	OAA Factor	Rate	0.25% Bonus W/H	10/1/2004 Rate
1	TANF	< 1		Male	175.02	0.9642	0.967			163.19	(.41)	162.78
2	TANF	< 1		Female	162.48	0.9642	0.967			151.49	(.38)	151.11
3	TANF	1 - 4		Male	79.46	0.9642	0.967			74.09	(.19)	73.90
4	TANF	1 - 4		Female	65.70	0.9642	0.967			61.26	(.15)	61.11
5	TANF	5 - 14		Male	60.04	0.9642	0.967			55.98	(.14)	55.84
6	TANF	5 - 14		Female	51.99	0.9642	0.967			48.47	(.12)	48.35
7	TANF	15 - 20		Male	70.34	0.9642	0.967			65.58	(.16)	65.42
8	TANF	15 - 20		Female	99.88	0.9642	0.967			93.13	(.23)	92.90
9	TANF	21 - 25		Male	91.27	0.9642	0.967			85.10	(.21)	84.89
10	TANF	21 - 25		Female	153.09	0.9642	0.967			142.74	(.36)	142.38
11	TANF	26 - 44		Male	205.51	0.9642	0.967			191.61	(.48)	191.13
12	TANF	26 - 44		Female	196.95	0.9642	0.967			183.63	(.46)	183.17
13	TANF	45 +		Male	516.46	0.9642	0.967			481.54	(1.20)	480.34
14	TANF	45 +		Female	375.98	0.9642	0.967			350.56	(.88)	349.68
15	ABAD	0 - 20		Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
16	ABAD	0 - 20		Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
17.1	ABAD	21 - 39	Medicare	Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
18.1	ABAD	21 - 39	Medicare	Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
17.2	ABAD	21 - 39		Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
18.2	ABAD	21 - 39		Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
19.1	ABAD	40 - 64	Medicare	Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
20.1	ABAD	40 - 64	Medicare	Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
19.2	ABAD	40 - 64		Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
20.2	ABAD	40 - 64		Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
21.1	ABAD	65 +	Medicare	Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
22.1	ABAD	65 +	Medicare	Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
21.2	ABAD	65 +		Male	673.56	0.9642		1.0451		678.74	(1.70)	677.04
22.2	ABAD	65 +		Female	673.56	0.9642		1.0451		678.74	(1.70)	677.04
23.1	OAA	0 +	Medicare	Male	510.56	0.9642		1.0451	0.758	389.98	(.97)	389.01
24.1	OAA	0 +	Medicare	Female	510.56	0.9642		1.0451	0.758	389.98	(.97)	389.01
23.2	OAA	0 +		Male	510.56	0.9642		1.0451	0.758	389.98	(.97)	389.01
24.2	OAA	0 +		Female	510.56	0.9642		1.0451	0.758	389.98	(.97)	389.01
Maternity Case Rate:					**3,600.76**	0.9642	0.967			3,357.28	(8.39)	3,348.89

ATTACHEMENT B

CONTRACTOR'S APPROVED SERVICE AREAS

CONTRACT # 071B5200007

ATTACHMENT B

GREAT LAKES HEALTH PLAN

APPROVED SERVICE AREA

Region 1
Wayne

Region 2
Hillsdale, Jackson, Lenawee, Livingston

Region 3
Berrien, Calhoun, Cass, Van Buren

Region 7
Huron, Saginaw, Sanilac, Tuscola

Region 9
Macomb, St. Clair

Region 10
Oakland