

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

December 28, 2005

**CHANGE NOTICE NO. 6
 TO**

CONTRACT NO. 071B5200018

**between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084 RomanK@Molinahealthcare.com		TELEPHONE (248) 925-1710 Roman T. Kulich
		VENDOR NUMBER/MAIL CODE (004)
		BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 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 immediately the attached three documents are hereby incorporated into this Contract. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency (Cheryl Bupp) and vendor (Michael Tegler) agreement and DMB/Acquisition Services approval.

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



MOLINA HEALTHCARE OF MICHIGAN

100 W. Big Beaver Road, Suite 600
Troy, Michigan 48084-5209
Toll Free 888-898-7969 or 248-925-1700
General Fax 248-925-1709
www.molinahealthcare.com

November 22, 2005

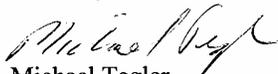
Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section 1-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed service agreement with Advosmas for your review.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,


Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget ✓





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DRAFT AGREEMENT

AGREEMENT between Molina HealthCare of Michigan, of Troy, Michigan, hereinafter referred to as "Provider" and ADVOMAS/Medicaid Assistance Service, Inc., whose address is 335 E. Big Beaver, Suite 100, Troy, Michigan 48083, hereinafter referred to as "Service".

1. Service's Responsibility. Service shall represent and assist patients in obtaining third-party reimbursement for hospital and medical charges. This will include pursuing payment from all sources other than Provider.

Service shall not act as Provider's representative for any patient without first obtaining their consent and shall obtain written acknowledgement from the patient that Service is not the Provider but is a separate corporation acting independently.

Service shall provide monthly reports of activity and performance to Provider.

Service shall report approvals on a monthly basis and provide timely invoicing to Provider.

2. Hold Harmless. Service shall hold Provider harmless for any and all actions of Service.

3. Responsibilities of Provider. Provider shall refer accounts timely and will provide and maintain a log of referrals for reconciliation purposes.

A. PAYMENT FOR APPROVED ACCOUNTS:

Provider shall pay Service according to the following fee schedule:

CSHCS application filing	\$350 flat fee
ESRD & other Medicare buy-ins	\$1,500 flat fee

If an approval is obtained through any other third party payer for an inpatient claim, Provider shall pay Service a fee of 35% of the monies saved by the plan for each individual claim.

B. PAYMENT FOR CONSULTING SERVICES:

Should Provider engage Service as a consultant, Provider shall pay Service a rate of \$150 per hour.

Provider shall pay Service within 30 days after receipt of invoice from Service. Provider and service shall reconcile approved account information on a monthly basis.

4. Termination. This contract will be terminable upon 30 days written notice by either party on the other.

5. Withdrawals from Representation. Provider shall have the right to instruct Service to forbear from pursuing any account upon notice to Service.

6. Review of Contract. An official review of performance and terms of the contract will be held within 45 days of the year anniversary of operation.

7. Contract Term. Contract is effective _____ through _____ and renews itself annually unless terminated by either party.

ADVOMAS/
Medicaid Assistance Service

Molina HealthCare of Michigan

By: _____

By: _____

It's: _____

It's: _____

Date: _____

Date: _____



MOLINA HEALTHCARE OF MICHIGAN

100 W. Big Beaver Road, Suite 600
Troy, Michigan 48084-5209
Toll Free 888-898-7969 or 248-925-1700
General Fax 248-925-1709
www.molinahealthcare.com

November 3, 2005

Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section 1-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed service agreement with The Myers Group for your review.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,

Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget ✓



**Proposal for
Administering Surveys**



**Molina Healthcare of
Michigan**

2006 Contract

November 1, 2005



improving the Business of Customer Satisfaction

2351 Henry Clower Boulevard • Suite D
Snellville, GA 30078-3107
Tel 770-978-3173
Fax 678-430-0080
www.themyersgroup.net



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1 CAHPS Project Overview

CAHPS Project Deliverables

The following is a list of standard deliverables included in the Fee Schedule Pricing:

Standard Deliverables	
A. Full Compliance with the HEDIS®/CAHPS 3.0H Protocol	Following the methodology as prescribed by the NCQA manual, HEDIS 2006, Volume 3 and additional information to be presented at NCQA vendor training.
B. Electronic Submission of Results to the NCQA	Results tabulated consistent with NCQA guidelines.
C. Printed Survey with Color Highlights	<ul style="list-style-type: none">• Commercial & Medicaid Adult: 4-page survey for adult surveys – 12 x 18 tabloid sized paper• Commercial Child: 4-page survey – 12 x 18 tabloid sized paper• Medicaid Child: 6-page survey – 11 x 25½• Commercial & Medicaid Child with CCC: 8-page survey – Two 11 x 17 tabloid sized paper
D. On-Line Reporting	During the data collection process, clients will have access to a confidential web site to monitor responses for each CAHPS project. This site will display sample size, timeline, protocol, and real-time returns as they are received. Results will be graphically displayed for key CAHPS questions and composites. Once weekly, results will be updated based on returns that have been scanned and verified.
E. Results Monitoring	At designated points during the protocol, our staff will advise you of the opportunity for The Myers Group to place reminder calls (during the mail phase) and initiate additional attempts during the phone phase to increase the number of completed surveys. This recommendation will be based on whether responses are meeting expectations as discussed with your Project Manager and based on historical response rates.
F. Interim Report	At the end of Wave 4, The Myers Group will provide clients a 3-page graphical report showing response rates overall and by member demographics. Responses and ratings for key attributes are also presented along with the 3-Point Score conversion rating for comparison to the HEDIS/CAHPS Mean from the prior reporting year. Composite scores are also provided. Where possible, the data will be compared to the 2005 Quality Compass national percentiles. Note that benchmark data is not available for CCC Surveys. Therefore, Interim Reports are not provided for this survey. Also note that Interim Reports will not be prepared for CAHPS 3.0H surveys that have had core questions altered.
G. Advising Smokers To Quit	Per NCQA's rotation cycle and moving average protocol, ASTQ is to be included in the 2006 adult survey. Results for 2005 will be added to results from 2006 for reporting purposes.
H. Flu Shot Measure	Per NCQA's rotation cycle and moving average protocol, the Flu Shot Measure is to be included in the 2006 adult survey. Results for 2005 will be added to results from 2006 for reporting purposes. The Myers Group will show the results for the entire group of respondents as well as the score for the specific age group – 50 to 64.



Standard Deliverables

I. Custom Questions

The Myers Group will assist the client in adding "custom" (scaled) questions to meet specific needs of the health plan. For designated questions, The Myers Group will provide a Book of Business Benchmark comparison with significance testing. Trending and significance testing to prior years will also be shown for identical questions. Note that these custom questions must fit within the confines of the standard survey paper size as outlined above in Section C. Only if custom questions cause the survey tool to exceed the confines of the standard survey paper size for the CAHPS survey(s) selected, an additional fee of \$1,000 will be billed for paper, printing, and additional data analytics.

J. Spanish Protocol

NCQA allows for an enhancement of the protocol to offer an opportunity for Spanish-speaking members to respond to the survey. There will be a brief statement printed on the reverse side of all letters and postcards offering Spanish-speaking members the opportunity to dial a 1-800 number to conduct the survey with a bi-lingual interviewer. There is no additional charge for this enhancement. A second option includes sending the survey in either English or Spanish based on member preference as indicated in health plan database, based on approval from NCQA. If requested, bi-lingual interviewers will conduct all interviews during the phone follow-up portion of the protocol. Please see "additional deliverables" for fees associated with the language preference option and use of the bi-lingual interviewers.

K. Telephone consultation on interpretation and use of survey results

Following shipment of the results report to your office, senior consultants and/or analysts are available for telephone conference calls and consultations with designated members of your staff. (One hour per sample/two hour maximum per plan. Any amount over the designated time will be billed at \$100/hr.)

L. Final Report

A detailed description/charts/tables of survey methodology, interpretation of results and comparison to benchmarks. Approximately 80 pages. The client will receive two bound color copies of the report and one electronic PDF file.

1. At-A-Glance report – A four-page report highlighting the CAHPS results will be presented within the two weeks after submission and verification of data. This report will show the profile of respondents, Quality Compass percentiles by composite, attribute, and rating questions, and three point scoring for accreditation.
 2. Executive Summary – A two-page report that summarizes and provides an executive level interpretation of results.
 3. Respondent Profile – The plan's Respondent Profile will be shown graphically by plan demographics and will be compared to the Quality Compass demographics.
 4. Quality Compass Benchmarks – NCQA's 2005 Quality Compass results (Publicly Reporting files) will be used for the Commercial Adult and Medicaid Adult samples. Where available, Quality Compass 2005 Regional benchmarks will be shown. Health plans will be requested to indicate up to 2 regions to be included in the report. All other products will be compared to NCQA benchmarks and thresholds, where available. Client will also have the opportunity to designate up to 5 competitor plans which publicly report data to Quality Compass for comparison of composites, attributes, rating questions, and HEDIS measures. Additional fees will apply (see below).
 5. Three Year Historical Trending – Trending from 2006's CAHPS 3.0H survey to 2005's CAHPS 3.0H survey will be provided. In addition, trending from 2006's CAHPS 3.0H survey to 2004 and 2003 CAHPS 3.0H data will be shown for each question. Significance testing for one-year and two-year trending will be performed. Note: A fee may apply for trending if the client is unable to provide historical data files in Excel, SPSS, or Access with labeled fields (columns) by question number. If NCQA member level files are submitted, there will be a trending charge.
 6. Accreditation Scores – The plan's 3-point scores will be shown with NCQA's scoring percentiles for Commercial Adult and Medicaid Adult samples.
-



Standard Deliverables

7. Question Summary – The distribution of the full set of responses will be shown and where possible compared to Benchmarks and historical results. Significance testing will be conducted for trending and benchmarks.
 8. Segmentation – Segmentation will examine results for subsets of respondents including: plan rating, age, education level, ethnicity, duration with the health plan, member health, and survey disposition.
 9. Regression Analysis – TMG Book of Business composite scores will be used to identify which composites are potentially the strongest drivers of two key areas - of overall satisfaction for the plan and overall satisfaction of the health care received.
 10. Correlation – Attribute scores will be correlated to the overall satisfaction for the health plan to determine which attributes are most strongly correlated to overall satisfaction. In addition, specified custom questions will also be correlated to overall satisfaction.
 11. Opportunity Grid – Plan composite scores will be identified and segmented by the identification of a key driver(s) and the comparison to the benchmark.
 12. Loyalty Index – If the loyalty questions are selected as custom questions, a composite index score will be developed to measure member loyalty and correlate results to member satisfaction.
 13. Banner Tables – Cross-tabs will provide a systematic tabulation and display of results by respondent segment (i.e., plan rating, age, education level, duration with the plan, method of data collection) for all choices of all questions.
 14. SPSS data on CD-Rom – Upon request, data will be sent via CD-Rom and included in final report. Data will be cleaned of all member-level data to protect confidentiality.
 15. Technical Notes – Detailed description of survey processes, analysis methodology, information on benchmarking, and application of results to accreditation.
-



CAHPS Fee Schedule

The Myers Group's fee schedule for the 2006 CAHPS surveys is presented below. Discounts are available for multiple samples. Please refer to CAHPS Project Deliverables for a description of all services and deliverables.

CAHPS 3.0H Survey	Sample Size	Fee	# of Samples	Fee Total
Medicaid Adult Sample 6 custom questions 20% over-sample (270 additional surveys) MAHP comparative report MDCH Aggregate report	1,350	\$15,500	1	\$15,500
CAHPS Subtotal:				\$15,500



CAHPS Additional Deliverables

The following is a list of additional deliverables available from The Myers Group.

Additional Deliverables		
A.	Additional Custom Questions – Only if custom questions cause the survey tool to exceed the confines of the standard survey paper size for the CAHPS survey(s) selected by the client, an additional fee applies.	\$1,000
B.	Interspersion of Custom Questions – NCQA allows custom questions to be placed at specified insertion points within the core survey tool. Final placement of interspersed custom questions is subject to NCQA approval.	\$1,000
C.	Historical Trending (using non-TMG data specs) – There will be no charge for historical trending if the client provides data files in Excel, Access, or SPSS with labeled fields (columns) by question number. If client must submit NCQA member level files for trending, there will be an additional charge for each year trended.	\$500 fee is waived when client provides data files as defined
D.	Submission of results to other organizations – When CAHPS results must be submitted to parties other than NCQA and require data/reports to be submitted in a layout different or altered from NCQA specifications or The Myers Group's standard format, this fee will apply.	\$100 per hour
E.	Over-sampling – NCQA allows for over-sampling up to 30% of the database.	\$550 per 100 members
F.	Customized benchmarking – Client will have the opportunity to designate up to 5 competitor plans which publicly report data to Quality Compass for comparison of composites, attributes, rating questions, and HEDIS measures.	\$1,000
G.	Open-ended Questions – Verbatim comments will be indexed to respondent demographics	\$400 per question
H.	PowerPoint Presentation – A summary of CAHPS results is prepared and ready for presentation to key personnel at the health plan. Details of the CAHPS survey including sampling, methodology, trending, benchmark comparisons, significance, and key driver analysis will be shown in a concise, professional format.	\$750
I.	On-site Presentation – A senior consultant will present survey results, on-site, to your designated staff.	\$1,000 + travel expenses
J.	Banner Tables/Segmentation – Additional banner tables and accompanying segmentation summaries beyond the standard deliverable banner tables may be ordered by "segmentation groups" (i.e., employer group, regional group, etc.)	\$300 per group
K.	Additional Analysis – Analytic work or reports requested, in addition to the reports included in the package.	\$100 per hour
L.	Spanish Mailing Preference - Upon approval from NCQA, an enhanced methodology will be implemented which includes sending the survey in either English or Spanish based on member preference as indicated in health plan database.	\$2,000



Additional Deliverables	
M. Outbound Bilingual (English/Spanish) CATI Interviewers – The Myers Group will assign bi-lingual interviewers to your sample.	\$500
N. Color Logo/Letterhead – The Myers Group standard cover letter consists of black type with color logo/letterhead (1 PMS color). Additional PMS colors over The Myers Group's standard (1 PMS color) will be charged at \$300 per additional PMS color	\$300 per PMS color
O. Additional Copies of the Final Report	\$45 per report
P. Member Data Layout Specification – The Myers Group requires data files to arrive using a comma-delimited format with double quotes as text qualifiers or no commas in text fields. Use the option fields to capture data not referenced specifically on this layout, such as age, county, product groups, etc. <u>Pricing Note:</u> Programming fee only applies if data files not submitted per TMG specs.	\$50 setup fee + \$50 per hour programming fee



CAHPS Additional Deliverables

Additional Deliverables	Fee	Qty	Ext Fee Total
Custom questions cause the survey tool to exceed the confines of the standard survey paper size	\$1,000		
Interspersion of questions	\$1,000		
Historical trending (using non-TMG compliant data specs)	\$500		
Customized benchmarking (please indicate health plan names/product names that should be included in the report.)	\$1,000		
Submission to other organizations (if different submission specs required)	\$100 per hour		
Over-Sampling	\$550 per 100 members	270	\$1,485
Spanish mailing preference	\$2,000		
Outbound bilingual (English/Spanish) CATI interviewers	\$500		
Open ended questions	\$400 per question		
On-site presentation	\$1000 + travel expenses		
PowerPoint Presentation	\$750 per sample		
Banner Tables – Segmentation Analysis	\$300 per grouping		
Additional Analysis	\$100 per hour		
Color Logo/Letterhead (1 color included in fee)	\$300 per PMS color		
Development of logo if submitted logo is not print-ready	\$250		
Member Data Layout Programming (only applicable if data files not submitted per TMG specs)	\$50 setup fee + \$50 per hour		
Additional color report copies	\$45 per report		
CAHPS Total:			\$16,985
Client Initials:			



CAHPS Augment Fee Schedule

Plans may also augment the sample by using a stratified sample to target specific responses in a particular segment, such as region, provider group, or large employer group. These responses are for internal use only and not to be included in the HEDIS sample or reported to public entities.

The Myers Group's fee schedule for the augment of 2006 CAHPS surveys is presented below. Please refer to CAHPS Project Deliverables for a description of all services and deliverables.

Please indicate the objective and type of the augment and analysis:

Augment Description (specify sample sizes, if available)	
Provider Group:	
Region:	
By zip code:	
By county:	
By description:	
Employer Group:	

Augment Fee Schedule	Fee	No. of Members	Ext Fee Total
Augmentation			
1) Survey printing and 4 wave mail distribution, OR	\$450 Per 100 Members		
2) Full NCQA protocol of mail plus phone follow-up to all non-respondents	\$550 Per 100 Members		
3) Banner-segmentation analysis per grouping - Additional banner tables and accompanying segmentation summaries beyond the standard deliverable banner tables may be ordered by "segmentation groups" (i.e., employer group, regional group, etc.)	\$300 Per Grouping		
4) Question summaries showing all response options	\$250		
5) A separate "full report" fee, if ordered	\$2,000		
Augment Total:			
CAHPS and Augment Total:			
Client Initials:			



Augment Additional Deliverables		
A.	Banner Tables/Segmentation	\$300 per group
B.	Additional Analysis – Analytic work or reports requested, in addition to the reports included in the package.	\$100 per hour
C.	Outbound Bilingual (English/Spanish) CATI Interviewers – The Myers Group will assign bi-lingual interviewers to your sample.	\$500
D.	Color Logo/Letterhead – The Myers Group standard cover letter consists of black type with color logo/letterhead (1 PMS color). Additional PMS colors over The Myers Group's standard (1 PMS color) will be charged at \$300 per additional PMS color.	\$300 per PMS color
E.	Additional Copies of the Final Report	\$45 per report
F.	Member Data Layout Specification – The Myers Group requires data files to arrive using a comma-delimited format with double quotes as text qualifiers or no commas in text fields. Use the option fields to capture data not referenced specifically on this layout, such as age, county, product groups, etc. <u>Pricing Note:</u> programming fee only applies if data files not submitted per TMG specs.	\$50 setup fee + \$50 per hour programming fee



CAHPS Activity Schedule

Below is the generic Activity Schedule for administering the CAHPS Survey (The Myers Group is indicated by TMG). A specific timeline will be incorporated into the Project Guidebook.

	Activity	Who	When
A.	Project Start – Project starts when signed agreement and advance fee are received by The Myers Group.	Client	
B.	Project Readiness – We will provide you with the required text for letters, the core survey tool, and instructions for preparing the database.	TMG	Week 1
C.	Design Information – Client will provide The Myers Group with necessary information to begin designing the survey and mail pieces (such as print-ready logo, signature, etc.).	Client	Week 2
D.	“Custom” Questions – With feedback from key client representatives and guidance from The Myers Group, the client compiles a list of desired “custom questions” to be added to the core survey.	Client	Week 3
E.	Eligible Member Database – Client will provide an electronic database of all members eligible to be surveyed (the “sample frame”) consistent with instructions and formats specified by The Myers Group and NCQA. Volume 3: HEDIS® 2006 – Specifications for Survey Measures states that the vendor must receive written confirmation from the health plan that the sample frame “has been verified by a certified auditor” prior to sampling. The Myers Group must receive a clean database by the date indicated on the Activity Schedule. If the database is not received as requested above, The Myers Group will ask the client to resubmit the files and this will delay the project and could jeopardize accreditation efforts. The client has the option to request that The Myers Group clean the database for additional fees.	Client	Week 4
F.	Survey Approval –Survey Design Customization, Review and Approval of Mailing Pieces	TMG	Week 5
G.	Sample Selection – Following the HEDIS/CAHPS 3.0H protocol, our Survey Management System will select a random sample of members to be surveyed from the database of eligible members provided from the health plan.	TMG	Week 5
H.	Print all required survey materials – Based on NCQA approval of blue-lines in 10 business days	TMG	Week 6
	Outgoing “4-Wave” Mail Handling		

Proposal for
Administering Surveys



	Activity	Who	When
	Send the customized survey.	TMG	Week 7
I.	Send thank you/reminder card 4-7 days after the questionnaire is mailed.	TMG	Week 8
	Send replacement questionnaire approximately 3 weeks after the initial questionnaire.	TMG	Week 10
	Send thank/you reminder card 4-7 days after replacement questionnaire is mailed.	TMG	Week 11
J.	Telephone Follow-Up and Interviews – We will begin making telephone attempts to all non-respondents 21 days after the replacement questionnaire has been mailed. The telephone interviews will last approximately 22 days.	TMG	Week 14-20
K.	Analysis and Results Reporting – The Myers Group will perform and report analysis according to contract. For those plans submitting to NCQA, The Myers Group will deliver member level files to NCQA as requested.	TMG	Week 21-24



2 Project Terms and Conditions

This agreement is between Patient Satisfaction Plus, LLC, d/b/a The Myers Group and Molina Healthcare of Michigan (Client).

1. The fee for the CAHPS project is \$16,985. Unless otherwise noted, CAHPS project fee quotes are inclusive of all costs The Myers Group will incur related to this project and as outlined in the "CAHPS Fee Schedule" section. In the event the Client requests supplementary work, a Scope Change Form (SCF) will be forwarded to the Client for review and signature. Scope Change Forms become part of this agreement and work will be charged at the rates described in the "CAHPS Additional Deliverables" section.
2. Survey projects described in Section 6, Attachments A – E, may be added to this agreement via the Master Contract Summary, as described in Section 5. In the event additional projects are not contracted simultaneously with the execution of this agreement, The Myers Group will, at any time during Calendar Year 2006, accept a Scope Change Form and the completed Fees Page to begin any project(s) described in Section 6, Attachments A – E. Total project fees are \$16,985 as described in Master Contract Summary.
3. Project fees will be invoiced and due as follows: CAHPS survey projects will be billed 75% of the project fee in advance, 15% on June 1, and 10% upon delivery of the final report(s). Additional fees the Client incurs, as evidenced by a Scope Change/Supplementary Projects Form (see Section 4), will be included on the final invoice.

All other survey projects, if applicable, described in Section 6, Attachments A – E will be billed 75% of each project fee in advance; 25% of each project fee will be billed at the conclusion of each project; additional project fees the Client incurs, as evidenced by a Scope Change/Supplementary Projects Form, will be included in the final project invoice.

4. Project Terms and Agreement may be amended to include additional projects as indicated by the Scope Change/Supplementary Projects Form. Client agrees to provide all required items within a reasonable timeframe as described in the "CAHPS Activity Schedule". The Client understands that variances to this timeframe, through no fault of The Myers Group, will alter the "Activity Schedule" timeline.
5. This proposal is based on the information regarding HEDIS®/CAHPS™ 3.0H surveys and protocol stipulated by the NCQA as of the proposal date. Modifications required by NCQA may require adjustments to this document and the price offered.
6. Client acknowledges that the National Committee for Quality Assurance ("NCQA") certifies vendors to produce HEDIS®/CAHPS™ 3.0H Survey Results. Client agrees that it will not seek damages or otherwise seek to hold NCQA liable in any manner for any actions of a HEDIS® survey vendor or any HEDIS®/CAHPS™ 3.0H Survey Results produced by a HEDIS® survey vendor.
7. The parties shall comply with all applicable statutes, rules, regulations and standards of any and all governmental authorities and regulatory and accreditation bodies relative to Health Care Organizations and the operation of the Client.



8. In the performance of all obligations hereunder, the parties shall be deemed to be independent contractors and Client shall not withhold or in any way be responsible for the payment of any federal, state or local income or occupational taxes, FICA taxes, unemployment compensation or workers' compensation contributions, vacation pay, sick leave, retirement benefits, or any other payments for or on behalf of the other party. All such payments, withholdings, and benefits are the responsibility of The Myers Group and The Myers Group shall indemnify and hold Client harmless from all loss or liability arising with respect to such payments, withholdings, and benefits. The Myers Group employees shall not be considered employees of Client for any purpose whatsoever.
9. This Agreement may not be assigned by The Myers Group, without the express written consent of Client.
10. This Agreement may be amended at any time by mutual agreement of the parties, if before any amendment shall be operative or valid, it shall have been reduced to writing and signed by both parties. If any provision of this Agreement is found to be in conflict with the provisions of any governmental law, rule, or regulation, such provision shall be severable and the remainder of this Agreement shall not be impaired and shall remain in full force and effect.
11. There are no other agreements or understandings, either oral or written, between the parties affecting this Agreement, except as otherwise specifically provided for or referred to herein. This Agreement cancels and supersedes all previous agreements between the parties relating to the subject matter covered by this Agreement. No change or addition to, or deletion of, any portion of this Agreement shall be valid or binding upon the parties hereto unless the parties approve the same in writing.
12. The Myers Group will comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and Title V of the Gramm-Leach-Bliley Act related to the privacy of Protected Health Information and Nonpublic Personal Financial Information. The Myers Group will neither use nor disclose Protected Health Information or Nonpublic Personal Financial Information it creates or receives for or from Client or from another business associate of Client, except as permitted or required by the Agreement or as required by law or as otherwise permitted in writing by Client.
13. The Myers Group will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards, in compliance with the above-mentioned legislation, to preserve the integrity, confidentiality and to prevent non-permitted use or disclosure of Protected Health Information or Nonpublic Personal Information created or received for or from Client.
14. This Agreement shall be construed and enforced under and in accordance with the laws of the State of Michigan.
15. Nothing in this Agreement shall be construed as creating or giving rise to any rights in any third parties or any persons other than the parties hereto.
16. This Agreement shall be binding upon the successors or assigns of the parties hereto.



17. All information, including, but not limited to, operational procedures, service protocols, pricing and statistical data, furnished or disclosed by either party to the other party, shall remain the property of the disclosing party. Each party agrees not to disclose such information to any third party or otherwise use the information for any purpose inconsistent with this Agreement. This section shall survive the termination of this Agreement.
18. Additional terms and conditions: Attachments including the Project Overview, Project Deliverables, and Fee Schedule are hereby incorporated into the Project Terms and Conditions and accepted by each party as verified by the signatures below.
19. Either party may terminate this Agreement, at any time and for any reason with thirty days (30) prior written notice to the other party. In the event of such termination, Molina Healthcare of Michigan will be responsible for the value of services rendered up to the time of termination. Molina Healthcare of Michigan will be refunded a pro rata portion of any amounts that were prepaid.
20. This Agreement may be renewable for successive annual terms as provided herein, upon approval of both parties mutual agreement of the fee schedule and Contract Amendment Form.

**Patient Satisfaction Plus, LLC
d/b/a The Myers Group**

Molina Healthcare of Michigan

By: _____	By: _____
Name: Amy Empric	Name: _____
Title: Account Executive	Title: _____
Date: _____	Date: _____
Company Address: 2351 Henry Clower Blvd, Suite D Snellville, GA 30078-3107	Company Address: _____
Email: aempric@themyersgroup.net	Email: _____
Fax: 678-430-0080	Fax: _____



3 Business Associate Agreement

This Business Associate Agreement (Agreement) is entered into effective as of November 1, 2005 by, and among Molina Healthcare of Michigan (Covered Entity) and Patient Satisfaction Plus, LLC, dba The Myers Group (Business Associate). The purpose of this Agreement is to comply with 45 C.F.R. §164.502(e) and §164.504(e), governing protected health information ("PHI") and business associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (statute and regulations hereafter collectively referred to as "HIPAA").

Statement of Agreement

§1. HIPAA Compliance and Agents: Business Associate hereby agrees to fully comply with the "Business Associate" requirements under HIPAA, throughout the term of this Agreement. Further, Business Associate agrees that to the extent it has access to PHI, Business Associate will fully comply with the requirements of HIPAA and this Agreement with respect to such PHI, and that every agent, employee, subsidiary, and affiliate of Business Associate to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity will be required to fully comply with HIPAA, and will be bound by written agreement to the same restrictions and terms and conditions as set forth in this Agreement.

§2. Use and Disclosure; Rights: Business Associate agrees that it shall not to use or disclose PHI except as permitted under this Agreement or as required by law. Business Associate acknowledges that this Agreement does not in any manner grant Business Associate any greater rights than Covered Entity enjoys, nor shall it be deemed to permit or authorize Business Associate to use or further disclose PHI in a manner that would otherwise violate the requirements of HIPAA if done by Covered Entity.

§3. Required or Permitted Uses: Business Associate agrees that it is permitted to use or disclose PHI only: (a) upon obtaining the authorization of the patient to whom such information pertains in accordance with 45 C.F.R. §164.502(a)(1)(iv) and §164.508, (b) upon obtaining the consent of a patient to whom such information pertains, if the use or disclosure is for purposes of treatment, payment, or health care operations, in accordance with 45 C.F.R. §164.502(a)(1)(ii) and §164.506, or (c) without an authorization or consent, if in accordance with 45 C.F.R. §164.506, §164.510, §164.512, §164.514(e), §164.514(f), §164.514(g), or as otherwise permitted or required by agreement or law.

§4. Safeguards Location: Business Associate agrees to develop and use appropriate procedural, physical, and electronic safeguards to prevent misuse of PHI other than as provided by this Agreement. Business Associate agrees to notify Covered Entity of the location of any PHI disclosed by Covered Entity or created by Business Associate on behalf of Covered Entity and held by or under the control of Business Associate or those to whom Business Associate has disclosed such PHI.

§5. Minimum Necessary: Business Associate must limit any use, disclosure, or request for use or disclosure to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of HIPAA. Business Associate represents that all uses, disclosures, and requests it will make shall be the minimum necessary in accordance with HIPAA requirements.



Covered Entity may reasonably rely, pursuant to HIPAA, on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate. Business Associate acknowledges that if Business Associate is also a covered entity, as defined by HIPAA, Business Associate is required, independent of Business Associate's obligations under this Agreement, to comply with the HIPAA minimum necessary requirements when making any request for PHI from Covered Entity.

§6. Records; Covered Entity Access: Business Associate shall maintain such records of PHI received from, or created or received on behalf of, Covered Entity and shall document subsequent uses and disclosures of such information by Business Associate as may be deemed necessary and appropriate in the sole discretion of Covered Entity. Business Associate shall provide the Covered Entity with reasonable access to examine and copy such records and documents of Business Associate during normal business hours. Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of HIPAA and any investigation of Covered Entity regarding compliance with HIPAA conducted by the U.S. Department of Health and Human Services ("DHHS"), Office of Civil Rights, or any other administrative or judicial body with jurisdiction.

§7. DHHS Access to Books, Records, and Other Information: Business Associate shall make available to DHHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity for purposes of determining the Covered Entity's or Business Associate's compliance with HIPAA.

§8. Designated Record Set; Individual Access: Business Associate shall maintain a designated record set, as defined by HIPAA, for each individual patient for whom it has PHI. In accordance with an individual's right to access to their own PHI under HIPAA, Business Associate shall make available all PHI in that designated record set to the individual to whom that information pertains, or such individual's representative, all PHI in that designated record set, upon a request by such individual or such individual's representative.

§9. Accounting: Business Associate shall make available PHI or any other information required to provide, or assist in preparing, an accounting of disclosures in accordance with HIPAA.

§10. Report of Improper Use or Disclosure: Business Associate shall report to Covered Entity any information of which it becomes aware concerning any use or disclosure of PHI that is not provided for by this Agreement.

§11. Amendment of and Access to PHI; Notification: Business Associate shall make available PHI for amendment and shall incorporate any amendments to PHI accordingly. Business Associate shall make reasonable efforts to notify persons, organizations, or other entities, including other business associates, known by Business Associate to have received the erroneous or incomplete information and who may have relied, or could foreseeably rely, on such information to the detriment of the individual patient. Business Associate must update this information when notified by Covered Entity.

§12. Termination Rights: Business Associate acknowledges and agrees that Covered Entity shall have the right to immediately terminate this Agreement in the event Business Associate fails to comply with HIPAA requirements concerning PHI and the above requirements.



This Agreement authorizes Covered Entity to terminate the Agreement, if Covered Entity determines, in its sole discretion, that Business Associate has violated a material term of the Agreement required by HIPAA.

§13. Breach or Violation; Knowledge: If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Agreement, Covered Entity shall take any steps reasonably necessary to cure such breach or end such violation, and, if such steps are unsuccessful, shall either (a) terminate this Agreement, if feasible, pursuant to §12, or (b) if termination is not feasible, report the breach or violation to DHHS. If Business Associate as a covered entity, defined by HIPAA, violates the terms and conditions of this Agreement in its capacity as a business associate of another covered entity, Business Associate will be in noncompliance with the standards, implementation specifications, and requirements of HIPAA.

§14. Return of PHI: Business Associate agrees that upon termination of this Agreement, and if feasible, Business Associate shall (a) return or destroy all PHI received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associate still maintains in any form and retain no copies of such information or, (b) if such return or destruction is not feasible, extend the protection of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

§15. Notices: All notices and other communications under this Agreement to any Party shall be in writing and shall be deemed given when delivered personally, telecopied (which is confirmed) to that Party at the telecopy number for that Party set forth at the end of this Agreement, mailed by certified mail (return receipt requested) to that Party at the address for that Party set forth at the end of this Agreement (or at such other address for such Party as such Party shall have specified in a notice to the other Parties), or delivered to Federal Express, UPS, or any similar express delivery service for delivery to that Party at that address.

§16. Non-Waiver: No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

§17. Gender and Numbers; Headings: Where permitted by the context, each pronoun used in this Agreement includes the same pronoun in other genders and numbers, and each noun used in this Agreement includes the same noun in other numbers. The headings of the various sections of this Agreement are not part of the context of this Agreement, are merely labels to assist in locating such sections, and shall be ignored in construing this Agreement.

§18. Counterparts: This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which taken together shall constitute the same Agreement.

§19. Entire Agreement: This Agreement constitutes the entire agreement and supersedes all prior agreements and understandings, both written and oral, among the Parties with respect to the subject matter of this Agreement.



§20. Binding Effect: This Agreement shall be binding upon, inure to the benefit of and be enforceable by and against the Parties and their respective heirs, personal representatives, successors, and assigns. Neither this Agreement nor any of the rights, interests or obligations under this Agreement shall be transferred or assigned by Business Associate without the prior written consent of Covered Entity.

§21. Severability; Governing Law: With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect. This Agreement shall be governed by and construed in accordance with the laws of the State of Michigan.

§22. Survival: All representations, covenants, and agreements in or under this Agreement or any other documents executed in connection with the transactions contemplated by this Agreement, shall survive the execution, delivery, and performance of this Agreement and such other documents.

§23. Further Assurances: Each Party shall execute, acknowledge or verify, and deliver all documents that may from time to time be reasonably requested by the other Party to carry out the purpose and intent of this Agreement.

Acknowledged and agreed to by:

**Patient Satisfaction Plus, LLC
d/b/a The Myers Group**

Molina Healthcare of Michigan

By:

By:

Name: Amy Empric

Name:

Title: Account Executive

Title:

Date:

Date:



4 Scope Change/Supplementary Project Form

This form will be completed and sent to you for your approval if the scope of your project has changed compared to the terms/deliverables outlined in the contract OR if you request additional work and deliverables.

Sample Number:			
Project Name:			
Project Manager Name:			
Requestor's Name (Client's Name):			
Date of Request:			
Type of Request	Description of Change or Work To Be Done	Charges/Fees To Be Applied	Approval (Client Initials)
> Scope Change			
> Additional Work			
> Scope Change			
> Additional Work			
> Scope Change			
> Additional Work			
> Scope Change			
> Additional Work			
> Scope Change			
> Additional Work			

In order for the requested changes or additional work to be completed, please sign below indicating you agree with the description of work and the fees associated with this (if applicable).

Client Signature

Date of Approval



5 **Master Contract Summary**

The Myers Group grand total fee for all proposed survey projects for Molina Healthcare of Michigan from January 2006 to December 2006 is presented below. (CAHPS projects start date may be October, November, or December 2005 with data collection to begin in January 2006.)

Survey Projects	Projected Start Date (Month/Year)	Total Fee
CAHPS Survey Project(s) Total		\$16,985
CAHPS Augment Total		
Attachment A-3: Provider Survey		
Attachment B-3: Patient Satisfaction with Provider Survey		
Attachment C-3: ECHO Survey		
Attachment D-3: Call Satisfaction Survey		
Attachment E-3: New Member/Welcome Calls		
	Grand Total:	\$16,985
	Client Initials:	



6 Additional Survey Project Descriptions

In the following attachments, The Myers Group presents descriptions of additional survey projects for which Molina Healthcare of Michigan may contract under this agreement. Additional contracted survey projects are included on the Master Contract Summary in Section 5.



Attachment A: Provider/Practice Manager Satisfaction

Attachment A.1: Project Overview for Provider/Practice Manager Satisfaction

NCQA Standard UM 11 (Satisfaction with the UM Process) currently directs that at least annually, managed care organizations gather information regarding provider satisfaction with the UM process. The Myers Group offers three core survey options for plans to measure provider satisfaction:

Provider Satisfaction Survey	
Description & Purpose of Survey	<p>The Provider Satisfaction Survey targets physician providers to measure their satisfaction with the health plan. Providers will also compare their satisfaction with the plan compared to other plans in which they participate.</p> <p>The plan may choose the practice manager phone follow-up option to improve the response rates if necessary.</p>
Survey Design	<p>Each survey consists of 25 - 30 scaled core questions, 4 - 8 demographic questions, and 2 open-ended questions. The Myers Group will assist you in preparing additional custom scaled questions. The questionnaire is printed in black ink on a 4-page folded survey (11 x 17 paper). Design customization of the survey may be permitted within survey space constraints. If the number of custom questions necessitates a larger paper size, an additional fee of \$1000 will be charged. The client will be given the option to reduce the number of custom questions (to fit on the 11 x 17 paper) or to incur the additional charges.</p>
Sample Size	<p>The client will submit a complete database of eligible providers. The Myers Group will sample up to 1,500 providers. If desired, over-sampling can be conducted for an additional fee. For plans with fewer than 1,500 providers, The Myers Group will sample 100% of eligible providers.</p> <p>The Myers Group will stratify the sample to include the majority of primary care providers and a random selection of specialists. We can also stratify the database to include 100% of key groups, such as the plan's "top 100" practices.</p>
Survey Administration	<p>The survey will be administered by US mail, with a "2-wave" contact attempt as follows:</p> <ol style="list-style-type: none"> 1. Send questionnaire/cover letter. 2. Send replacement questionnaire/cover letter 2 - 3 weeks post wave 1 to non-respondents. 3. (Optional) Conduct follow-up phone calls to Practice Managers of non-respondent practices and obtain survey completes via CATI. Typically, the plan identifies a group (or subset of the sample) of key provider practices for which obtaining satisfaction information is highly desirable.



Provider Satisfaction Survey																							
Response Rate	Typically, 20 – 25% for provider only and 25 – 40% when practice manager follow-up surveys are performed.																						
Time Frame	Typically, this project can be completed in 11 weeks with work beginning when the signed contract and advance fees are received. If applicable, depending upon the number of optional practice manager survey phone calls, the project may take an additional 1 – 3 weeks.																						
Standard Base Fees	<p>The standard base fees include all costs for printing, postage, reply postage, letter-shop, database/sample management, survey scanning, project management and analytics (final reports). Fees are as follows:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Sample Size</th> <th style="text-align: center;">Fees</th> </tr> </thead> <tbody> <tr> <td>Fewer than 1000 providers</td> <td style="text-align: right;">\$9,950</td> </tr> <tr> <td>1000 – 1299 providers</td> <td style="text-align: right;">\$10,700</td> </tr> <tr> <td>1300 – 1500 providers</td> <td style="text-align: right;">\$11,550</td> </tr> </tbody> </table>	Sample Size	Fees	Fewer than 1000 providers	\$9,950	1000 – 1299 providers	\$10,700	1300 – 1500 providers	\$11,550														
Sample Size	Fees																						
Fewer than 1000 providers	\$9,950																						
1000 – 1299 providers	\$10,700																						
1300 – 1500 providers	\$11,550																						
Additional Fees	<p>The following describes the fee schedule for additional survey protocols, added questions, and analysis the client may elect to include.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Added Services</th> <th style="text-align: center;">Fees</th> </tr> </thead> <tbody> <tr> <td>Follow-up survey call to Manager</td> <td style="text-align: right;">\$450 CATI set up; + \$13.00 per completed survey</td> </tr> <tr> <td>Additional custom scaled questions</td> <td style="text-align: right;">No charge if scaled questions fit on 11 x 17 paper; \$1000 if larger size/additional paper required</td> </tr> <tr> <td>Additional custom open-ended questions</td> <td style="text-align: right;">\$400 per question (includes verbatim comment processing)</td> </tr> <tr> <td>Over-sampling beyond 1500</td> <td style="text-align: right;">\$4.50 each additional provider</td> </tr> <tr> <td>Additional segmentation (6 are included in base price)</td> <td style="text-align: right;">\$400 per segmentation report</td> </tr> <tr> <td>Additional analysis</td> <td style="text-align: right;">\$100 per hour</td> </tr> <tr> <td>Color Logo/letterhead (1 color included in fee)</td> <td style="text-align: right;">\$300 per PMS color</td> </tr> <tr> <td>Development of logo if submitted logo is not print-ready</td> <td style="text-align: right;">\$250</td> </tr> <tr> <td>Additional color report copies</td> <td style="text-align: right;">\$45 per report</td> </tr> <tr> <td>PowerPoint Slides</td> <td style="text-align: right;">\$450</td> </tr> </tbody> </table>	Added Services	Fees	Follow-up survey call to Manager	\$450 CATI set up; + \$13.00 per completed survey	Additional custom scaled questions	No charge if scaled questions fit on 11 x 17 paper; \$1000 if larger size/additional paper required	Additional custom open-ended questions	\$400 per question (includes verbatim comment processing)	Over-sampling beyond 1500	\$4.50 each additional provider	Additional segmentation (6 are included in base price)	\$400 per segmentation report	Additional analysis	\$100 per hour	Color Logo/letterhead (1 color included in fee)	\$300 per PMS color	Development of logo if submitted logo is not print-ready	\$250	Additional color report copies	\$45 per report	PowerPoint Slides	\$450
Added Services	Fees																						
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Additional analysis	\$100 per hour																						
Color Logo/letterhead (1 color included in fee)	\$300 per PMS color																						
Development of logo if submitted logo is not print-ready	\$250																						
Additional color report copies	\$45 per report																						
PowerPoint Slides	\$450																						



Attachment A.2: Provider and Practice Manager Project Deliverables

The following table presents the proposed deliverables for Provider Satisfaction Survey.

Deliverables
<p>Analysis:</p> <p><u>Question Summary</u> – The distribution of the full set of responses for each scaled question is shown and where possible compared to The Myers Group's National Benchmark.</p> <p><u>Segmentation Analysis</u> – A comparison of results for up to six selected provider characteristics (area/specialty of practice, by number of physicians in practice, years in practice, # of years with plan, by client plan volume, by number of plans in which physician participates, by PHO membership, zip code/region, or by survey respondent type) will be shown by subsets.</p> <p><u>Banner Tables</u> – Cross-tabs provide a tabular display of results by all respondent segments (listed above) for all question responses.</p> <p><u>Trending</u> – The Myers Group will trend results for up to two years when possible.</p> <p><u>Correlation Analysis</u> – This will identify which attributes are potentially the strongest drivers of overall satisfaction for the plan.</p> <p><u>Opportunity Grid (Gap Analysis)</u> – Strengths and Opportunities will be identified by comparing your "provider satisfaction gap" (ratings of your health plan vs. ratings of all others) for each attribute and The Myers Group's provider satisfaction gap benchmark for the same attribute. Our current gap analysis is based upon the written survey modality.</p> <p><u>Loyalty Curve</u> – A composite index score will be developed to measure provider loyalty and correlate results to provider satisfaction (available with the use of the loyalty questions).</p>
<p>Comments Processing:</p> <p><u>Indexed Comments</u> – Verbatim comments will be indexed to key demographics (ex. area of practice, years in practice).</p>
<p>Final Reports:</p> <p>Two full-color, bound complete reports of the results will be shipped at the completion of the project. The report PDF file will be electronically delivered to the client.</p> <p><u>Executive Summary</u> – A concise one-page report summarizing survey results.</p> <p><u>Findings of the Survey</u> – A 25-30 page in-depth report and analysis of the survey results.</p>



Attachment A.3: Provider Survey Fee Schedule

Survey Option	Sample Size	Fee	Qty	Fee Total
Provider (mail)				
Provider with Practice Manager follow-up (phone)				
Survey Option Subtotal:				
Additional Deliverables	Unit Fee	Qty	Ext Fee Total	
Custom questions cause the survey tool to exceed the confines of the standard survey paper size – OR – extends survey phone time protocol beyond 10 minute average	\$1,000 – paper \$1.50 per completed phone interview			
Over-sampling beyond 1500	\$4.50 each additional provider or manager			
Open ended questions	\$400 per question - paper \$2.00 per complete – phone interview			
On-site presentation	\$1000 + travel expenses			
Invitation postcard to Manager	\$550			
PowerPoint Presentation	\$450			
Banner Tables – Segmentation Analysis	\$300 per grouping			
Additional Analysis	\$100 per hour			
Color Logo/Letterhead (1 color included in fee)	\$300 per PMS color			
Development of logo if submitted logo is not print-ready	\$250			
Additional color report copies	\$45 per report			
Provider Survey Total:				
Client Initials:				



Attachment B: Patient Satisfaction with Provider Surveys

Attachment B.1: Project Overview for Patient Satisfaction with Provider Surveys

Within this section of the proposal, The Myers Group presents an overview of the proposed project under which the Patient Satisfaction Survey would be administered.

Project Overview	
Description & Purpose of Survey	<p>The survey is designed to measure patient satisfaction and general experience with the physicians who contract with the health plan. This information may be used:</p> <ul style="list-style-type: none"> ➤ In contracting with physicians ➤ As a part of a Pay for Performance Program ➤ As general information to a physician about Customer Service issues
Survey Design	<p>The Patient Satisfaction Survey consists of 37-scaled questions. The content of the survey will include questions that pertain to the following areas:</p> <ul style="list-style-type: none"> ➤ Urgent Access to Care ➤ Regular or Routine Access to Care ➤ Specialty Services ➤ The Doctor ➤ Office and Office Staff ➤ Nursing Staff ➤ Calling The Doctor ➤ Overall Satisfaction <p>At the request of client, The Myers Group can add up to four custom questions with no additional fee. Custom questions will be appended at the end of the standard questions of that composite section.</p>
Sample Size	<p>Client will submit a complete database of eligible patients from each of the practices to be surveyed. The Myers Group will de-duplicate the database to include only one patient per household. If a practice has:</p> <ul style="list-style-type: none"> ➤ Less than 50 patients, they will not be included in the sample ➤ 51 to 100 patients, 100% of their patients will be included in the sample ➤ More than 100 patients, a random sample will be generated prior to CATI phone interviewing
Survey Administration	<p>The Myers Group recommends the phone methodology for the Patient Satisfaction Survey.</p>
Response Rate	<p>Calls will be made until 30 responses per physician are achieved. A minimum of 3 and a maximum of 6 attempts to reach each patient will be made.</p>
Time Frame from Start to Finish	<p>This survey can be completed in approximately 8 weeks. Work will begin as soon as The Myers Group receives the signed Project Terms and Approval page.</p>



Attachment B.2: Project Deliverables for Patient Satisfaction with Provider

Within this section of the proposal, The Myers Group describes the proposed deliverables for the Patient Satisfaction Survey.

Deliverables

Final Report:

A 20 to 25 page in-depth, written report and graphical analysis of the survey results is provided. Report delivery includes two full-color, bound complete reports of the results, shipped at the completion of the project, along with one PDF file, which is electronically delivered. The report includes the following components:

- Executive Summary – A report that summarizes and provides an executive level interpretation of results and survey methodology
 - Respondent Profile – The Respondent Profile will be shown graphically by demographics
 - Segmentation – Segmentation charts present summary ratings organized across patient and physician demographics
 - Banner Tables – Cross-tabs that provide a systematic tabulation and display of results
 - Question Summaries – The distribution of the full set of responses for each scaled question is shown.
 - Significance Testing with Trending – Where applicable, current practice scores are shown side by side as compared with last year's scores
 - Correlation Analysis – The correlation analysis shows the relationship between overall satisfaction and key drivers of satisfaction.
 - Loyalty Analysis – Presents an assessment of patient loyalty with practices broken into three zones: loyalty, defection and indifference
 - Individual Physician Report – An individual report for each physician that receives at least 30 survey responses is provided. This includes individual practice scores compared to overall health plan scores. An interactive Excel program to run physician reports is also provided.
-



Attachment B.3: Fee Schedule for Patient Satisfaction with Provider Surveys

Survey Options	Fee	Qty	Fee Total
Phone Methodology: Fees based on 30 completed interviews per physician (for example 30 completed interviews per 100 physicians) = 3,000 completed interviews.	\$30,000		
Survey Subtotal:			
Additional Deliverables	Fee	Qty	Ext Fee Total
Additional Practices at 30 completes per physician	\$300		
Additional Custom Questions – If custom questions cause the survey tool to exceed the confines of the standard survey paper size for the survey(s) selected by the client, an additional fee applies.	\$1,000		
Historical Trending (using non-TMG data specs) – There will be no charge for historical trending if the client provides data files in Excel, Access, or SPSS with labeled fields (columns) by question number. If client must submit NCQA member level files for trending, there will be an additional charge for each year trended. *Fee Note: fee is waived if client provides data files as defined by The Myers Group.	\$500*		
Open-ended Questions – Verbatim comments will be indexed to respondent demographics.	\$400 per question		
On-site Presentation – A senior consultant will present survey results, on-site, to your designated staff.	\$1,000 + travel expenses		
Banner Tables/Segmentation – Additional banner tables and accompanying segmentation summaries beyond the standard deliverable banner tables may be ordered by "segmentation groups" (i.e., employer group, regional group, etc.)	\$300 per group		
Additional Analysis – Analytic work or reports requested, in addition to the reports included in the package.	\$100 per hour		
Outbound Bilingual (English/Spanish) CATI Interviewers – The Myers Group will assign bi-lingual interviewers to your sample.	\$500		
Color Logo/Letterhead – The Myers Group standard cover letter consists of black type with color logo/letterhead (1 PMS color). Additional PMS colors over The Myers Group's standard (1 PMS color) will be charged at \$300 per additional PMS color.	\$300 per PMS color		
Development of logo if submitted logo is not print-ready	\$250		
Additional Copies of the Final Report	\$45 per report		

Proposal for
Administering Surveys



Member Data Layout Specification – The Myers Group requires data files to arrive using a comma-delimited format with double quotes as text qualifiers or no commas in text fields. Use the option fields to capture data not referenced specifically on this layout, such as age, county, product groups, etc. *Fee Note: programming fee applicable if data files not submitted per TMG specs.	\$50 setup fee + \$50 per hour program fee*		
Patient Satisfaction with Provider Total			
Client Initials:			



Attachment C: Experience of Care and Health Outcomes (ECHO) Surveys

Attachment C.1: Project Overview for ECHO Surveys

Project Overview	
Description & Purpose of Survey	The objective of the MCO ECHO Survey is to elicit consumer assessment about their behavioral health treatment, plan, and outcomes.
Survey Design	Two surveys were combined (the Consumer Assessment of Behavioral Health Services and the Mental Statistics Improvement Program), using the best aspects of both, to produce the questionnaire. The 3.0H ECHO was released in March 2003 and is the most recent survey developed by Harvard Medical School for use by MCOs measuring satisfaction of their members with behavioral health services. The primary difference between the MBHO and the MCO version is that the plan survey includes a few more items about administrative services, such as filling out paperwork and finding information in written materials. The survey is printed with color highlights and is a 4-page survey on 12 x 18 oversized tabloid paper.
Sampling Protocol	The sampling protocol consists of a straight (random) sample of enrollees who have received behavioral health services. MCOs may submit the full sample frame that contains the entire eligible population of enrollees. Eligibility is determined by length of enrollment and diagnosis codes. The Myers Group then randomly draws the sample of at least 1,305 or 1,825 enrollees, depending on the methodology selected, to receive a survey.
Survey Administration	MCOs have the option of selecting a mail-only protocol or a mixed-methodology of mail with telephone follow-up. Option 1 has been defined by NCQA as a seven-wave mail protocol with four questionnaire mailings and three reminder postcards. Option 2 is the mixed methodology, which consists of a six-wave mail protocol (three questionnaires and three reminder postcards) with telephone follow-up of at least three telephone attempts. Based on The Myers Group research and experience, this protocol is our recommended approach for health plans conducting the ECHO survey.
Response Rate	The response goal is to achieve a minimum of 100 responses for each ECHO 3.0H survey question.
Time Frame	Typically, this project can be completed in 13 weeks.



Attachment C.2: Project Deliverables for ECHO Survey

Deliverables

A. Printed Survey with Color Highlights

4-page adult survey – 12 x 18 oversized tabloid paper

B. Custom Questions

The Myers Group will assist the client in adding "custom" (scaled) questions to meet specific needs of the health plan. Note that these custom questions must fit within the confines of the standard survey paper size as outlined above in Section C. If custom questions cause the survey tool to exceed the confines of the standard survey paper size for the ECHO survey(s) selected, an additional fee of \$1,000 will be billed for paper, printing, and additional data analytics.

C. Spanish Protocol

If requested by the health plan, there will be a brief statement printed on the reverse side of all letters and postcards offering Spanish-speaking members the opportunity to dial a 1-800 number to conduct the survey with a bi-lingual interviewer. There will be no additional charge for this enhancement. (Please see "additional deliverables" for fees associated with Bi-lingual interviewers conducting all interviews during the phone follow-up portion of the protocol.)

D. Telephone consultation on interpretation and use of survey results

Following shipment of the results report to your office, senior consultants and/or analysts are available for telephone conference calls and consultations with designated members of your staff. (One hour per sample/two hour maximum per plan. Any amount over the designated time will be billed at \$100/hr.).

E. Final Report

A detailed description/charts/tables of survey methodology, interpretation of results and comparison to benchmarks. Approximately 80 pages. The client will receive 2 bound color copies of the report and one .pdf file delivered electronically.

1. Executive Summary – A two-page report that summarizes and provides an executive level interpretation of results.
 2. Respondent Profile – The plan's Respondent Profile will be shown graphically by plan demographics.
 3. Question Summary – The distribution of the full set of responses will be shown and where possible compared to Benchmarks and historical results. Significance testing will be conducted for trending and benchmarks.
 4. Segmentation – Segmentation will examine results for subsets of respondents including: plan rating, age, education level, ethnicity, member health, and survey disposition.
 5. Regression Analysis – The plan's composite scores will be used to identify which composites are potentially the strongest drivers of overall satisfaction for that plan.
 6. Correlation – Attribute scores will be correlated to the overall satisfaction for the health plan to determine which attributes are most strongly correlated to overall satisfaction.
-



Deliverables

7. Banner Tables – Cross-tabs will provide a systematic tabulation and display of results by respondent segment (i.e., plan rating, age, education level, duration with the plan, method of data collection) for all choices of all questions.
 8. Technical Notes – Detailed description of survey processes, analysis methodology, information on benchmarking and application of results to accreditation.
-



Attachment C.3: Fee Schedule for ECHO Surveys

This fee schedule indicates methodologies and fees for Sampling Protocol 1 (100% of sample is behavioral health members)

Survey Options	Sample Size	Fee	# of Samples	Fee Total
Mail-only methodology	1,825	\$14,650		
Mail plus phone methodology	1,305	\$15,650		
Survey Subtotal:				
Additional Deliverables	Fee	Qty	Ext Fee Total	
Additional Custom Questions – If custom questions cause the survey tool to exceed the confines of the standard survey paper size for the ECHO survey(s) selected by the client, an additional fee applies.	\$1,000			
Historical Trending (using non-TMG data specs) – There will be no charge for historical trending if the client provides data files in Excel, Access, or SPSS with labeled fields (columns) by question number. If client must submit NCQA member level files for trending, there will be an additional charge for each year trended *Fee Note: fee is waived when client provides data files as defined by TMG.	\$500*			
Submission of results to other organizations – When ECHO results must be submitted to parties other than NCQA and require data/reports to be submitted in a layout different or altered from NCQA specifications or The Myers Group's standard format, this fee will apply.	\$100 per hour			
Over-sampling – NCQA allows for over-sampling up to 30% of the database.	\$450 per 100 members			
Open-ended Questions – Verbatim comments will be indexed to respondent demographics	\$400 per question			
On-site Presentation – A senior consultant will present survey results, on-site, to your designated staff.	\$1,000 + travel expenses			
Banner Tables/Segmentation – Additional banner tables and accompanying segmentation summaries beyond the standard deliverable banner tables may be ordered by "segmentation groups" (i.e., employer group, regional group, etc.)	\$300 per group			
Additional Analysis – Analytic work or reports requested, in addition to the reports included in the package.	\$100 per hour			
Outbound Bilingual (English/Spanish) CATI Interviewers – The Myers Group will assign bi-lingual interviewers to your sample.	\$500			

Proposal for
Administering Surveys



Color Logo/Letterhead – The Myers Group standard cover letter consists of black type with color logo/letterhead (1 PMS color). Additional PMS colors over The Myers Group's standard (1 PMS color) will be charged at \$300 per additional PMS color.	\$300 per PMS color		
Development of logo if submitted logo is not print-ready	\$250		
Additional Copies of the Final Report	\$45 per report		
Member Data Layout Specification – The Myers Group requires data files to arrive using a comma-delimited format with double quotes as text qualifiers or no commas in text fields. Use the option fields to capture data not referenced specifically on this layout, such as age, county, product groups, etc. *Pricing Note: programming fee waived if data files submitted per TMG specs.	\$50 setup fee + \$50 per hour programming fee*		
ECHO Survey Total:			
Client Initials:			



Attachment D: Call Center Satisfaction Surveys

Attachment D.1: Project Overview for Call Center Satisfaction Surveys

Project Overview	
Description & Purpose of Survey	<p>The Call Center Satisfaction Survey is designed to evaluate health plan members Call Center experiences over the past three months.</p> <p>Respondents are asked about their satisfaction with the:</p> <ul style="list-style-type: none"> ➤ Last contact with the customer services department ➤ Accessibility of the customer service representative by telephone ➤ Customer service representative's ability to resolve issues or answer questions
Survey Design	<p>Client can customize the survey tool within the given time and space constraints.</p> <hr/> <p><u>Telephone Protocol</u> – The survey tool consists of 18 scaled, 3 open-ended, and 1 demographic question(s). The Myers Group will program the survey into the Computer Assisted Telephone Interviewing (CATI) system.</p> <hr/> <p><u>Mail Protocol</u> – The survey tool consists of 19 scaled, 2 open-ended questions, and is printed in black ink on the front/back of an 8½ x 11 sheet of paper. It is mailed in a #10 envelope and returned in a #9 (BRE) envelope to The Myers Group. Both the survey and #10 envelope will display the Client logo.</p>
Sample Size	<p>Client will supply a database containing names, addresses, and telephone numbers of all eligible members who have called the health plan's customer service department in the past 3 months.</p>
Survey Administration	<p><u>Telephone Protocol</u> – telephone interviewers will make successive contact attempts to eligible respondents using the CATI telephone system. The Myers Group will target 400 completes.</p> <p>The Myers Group recommends the phone methodology for the Call Center Satisfaction Survey.</p> <hr/> <p><u>Mail Protocol</u> – A "one wave" contact attempt to 2,500 prospective respondents. The response rate for a single wave mail campaign is approximately 15%-17% (375 – 425 completes).</p>
Time Frame	<p>The survey can be completed in:</p> <ul style="list-style-type: none"> ➤ Telephone Protocol - 6 weeks ➤ Mail Protocol - 9 weeks <p>Work will begin as soon as The Myers Group receives the signed Project Terms/Approval page and advance project fee.</p>



Attachment D.2: Call Satisfaction Project Deliverables

Deliverables

Executive Summary

A two page report that summarizes the methodology and provides an executive level interpretation of results is delivered at the end of the project.

Final Report

A 25-30 page in-depth written report and graphic analysis of the survey results, including a two full-color, bound complete reports of the results will be shipped at the completion of the project. One PDF file will be electronically delivered.

Banner Tables

Cross-tabs provide a systematic tabulation and display of results for all choices of all questions.

Question Summaries

The distribution of the full set of responses for each scaled question is shown.

Segmentation Analysis

Segmentation charts present summary ratings organized across respondent and call center demographics.

Comments Processing

Verbatim comments to open-ended questions will be indexed into a spreadsheet format.

Telephone Consultation

Following shipment of the results report to your office, senior consultants and/or analysts are available for telephone conference calls and consultations with designated members of your staff (one hour maximum)



Attachment D.3: Fee Schedule for Call Satisfaction Surveys

Survey Options	Fee	# of Samples	Fee Total
Telephone: 400 completed calls (targeted), project set-up, project management, reporting, and deliverables.	\$5,500		
Mail: "One wave" mail to 2,500 prospective respondents, project set-up, project management, reporting, and deliverables.	\$15,000		
Telephone (Ongoing): 1,600 completed calls (400 targeted quarterly), project set-up, project management, (quarterly) deliverables, and (quarterly/annual) reporting.	\$19,800		
Survey Options Subtotal:			
Additional Deliverables	Fee	Qty	Ext Fee Total
Additional Analysis	\$100 per hour		
Development of logo if submitted logo is not print-ready	\$250		
Color Logo/Letterhead (1 color included in fee)	\$300		
Additional color report copies	\$45 each		
Call Satisfaction Surveys Total:			
Client Initials:			



Attachment E: New Member Satisfaction/Welcome Calls

Attachment E.1: Project Overview for New Member Satisfaction/Welcome Calls

Project Overview	
Description & Purpose of Survey	<p>The New Member Satisfaction Survey identifies the satisfaction level of new members with the enrollment process in order for the client to design and implement interventions to impact the level of satisfaction.</p> <p>The survey will also assess member's knowledge of their benefits based on their orientation and marketing materials. Survey results will help the plan to design and implement interventions to impact the level of satisfaction.</p> <p>The results of member understanding and satisfaction levels will determine a benchmark to aid the marketing and member services departments.</p> <p>An NCQA RR requirement to monitor "new member understanding of its procedures to ensure that marketing communications are accurate, and acts on opportunities for improvement" will be fulfilled at 100% with The Myers Group New Member Survey.</p> <p>Additionally, this survey will help meet the NCQA QI requirement to assess the "linguistic needs of its members and adjust the availability of practitioners within its network, if necessary."</p>
Survey Design:	<p>Client can customize the survey tool within the given time and space constraints.</p> <p>The survey tool consists of 25-27 scaled questions that are divided among the following sections:</p> <ul style="list-style-type: none">➤ Introduction➤ Preliminary marketing questions➤ Overall satisfaction➤ Mailed marketing materials➤ Understanding of benefits➤ Detailed marketing questions➤ Questions related to ID cards➤ Member suggestions/questions <p><u>Mail Protocol</u> – The survey tool is printed in black ink on the front of an 8 ½ x 11 sheet of paper. It is mailed in a #10 envelope and returned in a #9 (BRE) envelope to The Myers Group. Both the survey and #10 envelope will display the Client logo.</p> <p><u>Telephone Protocol</u> – The Myers Group will program the survey into the Computer Assisted Telephone Interviewing (CATI) telephone system. The Myers Group survey lasts an average of ten minutes. The Myers Group will make up to 6 attempts to fulfill the above quota requirements.</p>



Project Overview

Recommended Sample Size:	Client will submit to The Myers Group a complete database containing names, addresses, and telephone numbers of eligible new members. Based on the size and completeness of the database, The Myers Group will aim to complete 400 quarterly, for one full calendar year. The Myers Group recommends that the health plan stratify the sample to include large employer groups that require satisfaction reporting.
Response Rates:	<u>Mail Protocol</u> – A "one wave" contact attempt to 2,500 prospective respondents. The response rate for a single wave mail campaign is approximately 15%-17% (375 – 425 completes). <u>Telephone Protocol</u> – The Myers Group telephone interviewers will make successive contact attempts to eligible respondents using the CATI telephone system. The Myers Group will target 400 completes per quarter. Regardless of mail or telephone protocol, The Myers Group will notify Client if any members note that they are very or completely dissatisfied. Names, addresses, and telephone numbers will be supplied to Client for these members as well as any comments they may make.
Time Frame:	Work will begin as soon as The Myers Group receives the signed Project Terms/Approval page and advance project fee. The survey can be completed in: > Mail Protocol – 6 weeks (one time) > Telephone Protocol – The entire project will be completed in about 4 weeks from the time The Myers Group receives a clean database every quarter.



Attachment E.2: Project Deliverables for New Member Satisfaction/Welcome Calls

Deliverables

Final Report

A 25-30 page in-depth written report and graphical analysis of the survey results. Two full-color, bound complete reports of the results will be shipped at the completion of the project. One PDF file will be electronically delivered to the client.

- Executive Summary – A one-page report that summarizes the methodology and provides an executive level interpretation of results and delivered at the end of the project.
- Banner Tables – Cross-tabs provide a systematic tabulation and display of results for all choices of all questions.
- Question Summaries – The distribution of the full set of responses for each scaled question is shown.
- Prompt resolution of new member issues – The Myers Group will notify Client if any members note they are very or completely dissatisfied. Names, addresses, and telephone numbers will be supplied to Client for these members as well as any comments they may make.

Additional Deliverables:

- Additional bound color report copies will be prepared for a fee of \$45 each.
- Analysis over and above our standard deliverables will be charged at \$100 per hour.
- A fee of \$300 per color will be charged if more than one color is requested on client letterhead.

Upon request and at no additional charge, The Myers Group will write a commentary on the findings of the survey that could be printed in a member newsletter. If the survey was conducted for an individual employer group, the "release" could be sent to the benefit manager of that group.



Attachment E.3: Fee Schedule for New Member Satisfaction/Welcome Calls

Survey Options	Fee	# of Samples	Fee Total
<u>Mail</u> : "One wave" mail to 2,500 prospective respondents, project set-up, project management, reporting and deliverables.	\$4,800		
<u>Telephone</u> : 400 completed calls (targeted), project set-up, project management, reporting and deliverables	\$5,000		
Telephone (ongoing): 1,600 completed calls (400 targeted quarterly), project set-up, project management, (quarterly) deliverables and (quarterly/annual) reporting	\$18,000		
Survey Options Subtotal:			
Additional Deliverables	Fee	Qty	Ext Fee Total
Additional Analysis	\$100 per hour		
Color Logo/Letterhead (1 color included in fee)	\$300		
Development of logo if submitted logo is not print-ready	\$250		
Additional color report copies	\$45 each		
New Member Satisfaction/Welcome Calls Total:			
Client Initials:			



MOLINA HEALTHCARE OF MICHIGAN

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www.molinahealthcare.com

December 13, 2005

Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section 1-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed service agreement with Outcomes, Inc. for your review.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,

Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget ✓



MASTER SERVICES AGREEMENT

This Agreement is entered into by and between Molina Healthcare of Michigan contracting on behalf of itself, and the other entities that are Client's Affiliates which are listed on the attached Exhibit "F" which is incorporated herein by reference (collectively referred to as "Client") and Outcomes, Inc. (Vendor").

Recitals

Client wishes to obtain certain documentation of its provider network, quality of services delivered to health plan Members by health care facilities and by physicians and other health care professionals, or validate certain data elements found in medical records or financial or other audits.

Vendor performs services including, but not limited to, site evaluations and assessments, HEDIS® medical record reviews, medical records audits, financial and billing audits, data validation, clinical data abstractions (hereinafter referred to as "Services") related to auditing, validating, and measuring the quality and appropriateness of health care services.

Client wishes to engage Vendor to act on its behalf to perform audit or other services as defined in the Scope of Work attached hereto as Exhibit A, and Vendor wishes to perform those services.

In consideration of the mutual promises made herein, the parties agree as follows:

1. Definitions

- 1.1. Definitions. Terms used in this agreement are defined in the Glossary, which can be found in Exhibit B, which is attached hereto and incorporated herein by reference.

2. Vendor Services

- 2.1. Services to be Provided. Vendor agrees to provide to Client the services indicated in Exhibit A of this Agreement. Payment for services is pursuant to the terms and conditions of Exhibit C of this Agreement, which is attached hereto and incorporated herein by reference.
- 2.2. All services for the 2006 HEDIS season will be delivered in accordance with an Implementation Schedule, attached hereto and incorporated herein as

MASTER SERVICES AGREEMENT

Exhibit "D". Unless mutually agreed otherwise in writing, Vendor and Client agree to the timelines set forth in the implementation schedule.

3. Client Provider Agreements; Assignment of Authority to Vendor

- 3.1. Client warrants and represents to Vendor that all provider network agreements between Client and its health care providers that participate in Client provider networks will include a provision stating that Client, or its designee, may review the services and/or medical records of participating providers. If any of Client's provider network agreements does not include said provision, Client will obtain said provision within fourteen (14) days after the effective date of this Agreement, and the timelines set forth in the implementation schedule, attached hereto as Exhibit D, will be adjusted accordingly.
- 3.2. Client shall provide to Vendor written authorization to act on behalf of Client in the review of services to confirm the documentation and/or quality and appropriateness of medical treatment as determined in guidelines provided by the health plan and the applicable services set forth in Exhibit "A" to this Agreement. Client shall notify the members of its provider network within seven (7) days prior to the beginning of the project timeline, as set forth in the implementation schedule attached hereto as Exhibit D, that it has authorized Vendor to act on behalf of Client in the review of medical records and inform network providers that they are obligated to share information and cooperate with Vendor under the Client provider agreement, and inform network providers that such information may be shared without violating the provisions of HIPAA or applicable state law.

4. Performance Guarantees

- 4.1. The penalties described in the Scope of Work, Exhibit "A", will not apply if Vendor's inability to perform is due to circumstances beyond Vendor's control, such as delays caused by or due to the fault of Client or due to the fault or delay of Client's Practitioners or Facilities, including, but not limited to delays in providing clean data or accurate samples, scheduling changes, restrictions on data collections, etc. As also provided in this Agreement, such penalties will not be applied in the event of a Force Majeure.

MASTER SERVICES AGREEMENT

5. Data Capture and Information Management

- 5.1. Vendor Forms. Unless otherwise agreed upon by the parties, Vendor will use its tools to notify and confirm providers and reviewers of scheduled appointments, and to create pull lists for providers and reviewers, where applicable.
- 5.2. Reports to Client. Vendor will provide to Client its standard project completion status reports accessible via Vendor's client portal (www.my-odis.com) available on-demand. Vendor will customize additional reports or perform custom database queries, as may be reasonably required by Client, for an additional fee to be agreed upon by Vendor and Client in writing prior to any such services.
- 5.3. Vendor will notify Client of any practitioner that cannot be reviewed and the reason that the review cannot be completed. Vendor will make three (3) attempts to locate and obtain access to records before reporting those records as unable to audit. Vendor will pend all charts for which it is unable to audit no later than 24 hours of learning the chart is non-retrievable and assign the appropriate non-retrievable reason code to describe why the chart is non-retrievable. Vendor will provide Client web-enabled access for reviewing and terminating or reactivating pended charts. These records are defined as non-retrievable charts and are considered completed by the Vendor for purposes of performance guarantees and fees.
- 5.4. Electronic Format. All data and reports to be provided by Client to Vendor and Vendor to Client shall be provided in electronic form with the exception of the actual chart copies retrieved by Vendor's reviewers. Data shall be exchanged in standard relational database formats specified by Vendor. Vendor may deliver information and reports to Client by electronic mail, or by posting such information and reports in a secure area of its web site.

6. Records and Access to Records and Ownership of Data and Work Product.

- 6.1. Vendor shall keep a record of its policies and procedures including, but not limited to, documentation of all actions taken with respect to such evaluations and reviews relating to its Services. The form and format of such records shall meet the standards of state and federal laws and regulations, as well as NCQA and JCAHO standards. Vendor shall maintain such records in accordance with Client's reasonable requests for compliance with state and federal laws and regulations, as well as NCQA and JCAHO



MASTER SERVICES AGREEMENT

standards for a period of up to seven (7) years, unless otherwise requested by Client and agreed upon by Vendor. Vendor shall provide Client with access to all records relating to its work on behalf of Client to enable Client to exercise its' right of audit, as provided in this Agreement. In addition, Vendor will allow, at Client's request, appropriate Health Oversight Agencies to have access to records as required for Client to comply with state and federal laws and regulations, and accreditation standards. At Client's request, copies of records will be made available to Health Oversight Agencies at no charge to the agency; provided, however, Vendor may charge Client for the reasonable cost of copying and delivering records to Health Oversight Agencies. Vendor may also charge Client its costs in responding to subpoenas from such agencies, including reasonable legal fees.

- 6.2. De-Identified Information. Vendor in performing its services under this Agreement shall be permitted to gather, collect, use, disclose, and maintain De-Identified Information (as defined in Exhibit "B" attached hereto) for use for any reasonable acceptable statistical or analytical purposes. Notwithstanding any other terms in this Agreement to the contrary, this Section 6.2 shall supersede and control over any other term or provision in this Agreement that might be in conflict herewith, and this Section 6.2 shall survive termination of this Agreement.

7. Privacy and Security of Health Information; HIPAA Compliance

- 7.1. Privacy of Protected Health Information. Vendor understands and acknowledges that it may receive from Client Protected Health Information ("PHI"), as defined under the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and/or nonpublic personal information ("Personal Information"), as defined under the Gramm-Leach-Bliley Act and implementing regulations ("GLB"), during the performance of its obligations under this Agreement.
- 7.2. With regard to its use and/or disclosure of PHI or Personal Information, Vendor hereby represents and warrants to Client that Vendor shall:
- 7.2.1. Not use or disclose any PHI other than as permitted by this Agreement or required by law except that Vendor may use De-Identified Data collected for statistical and analytical purposes.

MASTER SERVICES AGREEMENT

- 7.2.2. At all times maintain and use appropriate safeguards to prevent uses or disclosures of any PHI or Personal Information other than as permitted by this Agreement or required by law;
- 7.2.3. Ensure that any subcontractor or agent to whom it provides any PHI agrees in writing to the same conditions and restrictions that apply to Vendor with regard to the PHI, including, without limitation, all of the requirements of this Section 7.2.
- 7.2.4. Report promptly to Client any use or disclosure of any PHI of which it becomes aware that is not permitted by this Agreement;
- 7.2.5. Make its internal practices, books and records relating to the use and disclosure of PHI available to Client or to the Secretary of HHS for purposes of determining Client's compliance with the HIPAA privacy regulations.
- 7.3. The parties agree to take such action as is reasonably necessary to amend this Agreement from time to time for Client to comply with the requirements of HIPAA, the HIPAA privacy regulations, GLB and other federal and state privacy and consumer rights laws and regulations applicable to Client. Vendor agrees to reasonably cooperate with and assist Client in order for Client to meet its obligations under applicable privacy laws and regulations.
- 7.4. The terms and conditions of this Section required by HIPAA shall be construed in light of any applicable interpretation of and/or guidance on the HIPAA privacy regulation issued by HHS from time to time. Any ambiguity in this section shall be resolved in favor of a meaning that permits Client to comply with applicable laws and regulations.
- 7.5. Agreements required by HIPAA. Vendor will enter Business Associate and Chain of Trust agreements with Client as reasonably required for Client's compliance with the final HIPAA Privacy and Security rules enacted by HHS.

8. Fees and Taxes

- 8.1. Fees. Client recognizes that the cost to pay a reviewer to abstract a chart is only a fraction of the total cost to process a chart (which includes, but is not limited to, scrubbing data, zoning, loading, scheduling, printing tools for each chart, posting a nurse's scheduled appointments on the reviewer portal, my-odis.com, mailing nurse packets each week, abstraction, semi-weekly

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batching expense to return charts to Outcomes, receiving and logging in charts, performing inter-rater reliability testing (quality checks), data entry, tracking each chart to resolution, reporting, and uploading results to the client portal, www.my-odis.com, for Client access) and therefore acknowledges that Vendor will bill for all charts and/or sites in the final sample provided by Client.

- 8.2. Client agrees to pay Vendor for its services in accordance with Exhibit "C". The initial deposit is not refundable.
- 8.3. Taxes. The fees specified in this Agreement are exclusive of any Federal, state, or local excise, sales, and use taxes and assessments relating to goods and services provided hereunder. Client shall promptly pay any such applicable taxes (including penalties, if any) and assessments upon request of Vendor. Client shall have no responsibility for taxes based on the net income of Vendor.

9. General Terms and Conditions

- 9.1. Project Manager. Vendor and Client will each designate a Project Manager who will be responsible for and authorized to: (i) make decisions regarding the Vendor services; (ii) give any necessary approvals; and (iii) provide Vendor personnel with information and support for performance of the Vendor Services.
- 9.2. Confidential Information. Client agrees that all information regarding Vendor's systems, processes, procedures, and other proprietary information ("Confidential Information") is considered by Vendor to be a trade secret and is private and confidential and the Client will use no less efforts than it uses to protect its own "confidential information" to protect Vendor's Confidential Information. Client agrees to use Vendor's Confidential Information solely for the purpose of engaging the Services as contemplated by the Agreement and such information will be considered "Confidential Information". Confidential Information shall not include [a] information generally available to the public, [b] information Client legally had in its possession prior to receiving it from Vendor or [c] information independently developed by Client without reference to information received under this Agreement or from the Vendor.
 - 9.2.1. Client covenants and agrees that upon written request from Vendor, it will promptly deliver to the custody of the person designated by the



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Vendor all originals and copies of Vendor's Confidential Information in Client's care, custody or control and shall not retain any copies in whatever form including, but not limited to, any summaries or other descriptions of such information.

- 9.2.2. Client agrees that monetary damages would not be a sufficient remedy for breach of this Section. Therefore, in the event of any disclosure or other misappropriation of Vendor's Confidential Information in violation of this Agreement, Vendor shall be entitled to obtain from a court of jurisdiction an order restraining any further disclosure or misappropriation of such Confidential Information without the necessity of proving damages or posting bond in connection therewith, and such other and further relief (including, but not limited to, obtaining monetary damages and reasonable attorney's fees) as may be appropriate.
- 9.3. Client Right of Audit. Client, and any Health Oversight Agency which is reviewing Client's activities with Client's permission, shall have the right, upon not less than five (5) business days' prior written notice, to audit or otherwise inspect the operation of Vendor as it pertains to its work on behalf of Client under this Agreement. Such audit shall be conducted with due regard for not interfering with Vendor's other business and responsibilities. Client may conduct such audit at least annually to evaluate whether Vendor's activities are being conducted in accordance with state and federal laws and regulations, Client's expectations and applicable accreditation standards.
- 9.4. Delays. If Client, or any third party acting on Client's behalf, does not provide any required item or service to Vendor on a timely basis, then the dates set forth in the Implementation Plan shall be extended as reasonably necessary to account for such delay, and such delay may nullify Vendor's performance guarantees.
- 9.5. Modifications to Scope of Work; Changes. Client will notify Vendor in writing of any changes that it wishes to make to the Scope of Work to be performed by Vendor. If Vendor wishes to perform additional services, it will provide Client with a cost estimate and schedule impact for performing the modifications and/or additional services. Upon Client's acceptance of the changes in the scope, payment for and schedule of work, Vendor will proceed to perform the work as agreed to by the parties.

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- 9.6. Independent Contractors. The parties are independent contractors. Nothing in this Agreement shall be deemed to constitute a partnership or joint venture between them, nor shall anything in this Agreement be deemed to make one the agent of the other (except to the extent that Vendor acts as the agent of Client in the conduct of providing Services). Neither party shall be or become liable or bound by any representation, act or omission of the other.
- 9.7. Warranty and Limitation of Damages. Vendor represents that the Vendor systems are free from material program error, to the best of its current knowledge and belief. If any material program error is discovered by the Client, Client will promptly notify Vendor of such error. Vendor shall promptly attempt to correct such error at no cost to Client. Vendor assumes no responsibility or liability beyond correcting the material program error. The rights and remedies granted to the Client under this paragraph constitute the Client's sole rights and remedies against Vendor and its directors, officers, agents and employees.
- 9.7.1. THE ABOVE IS A LIMITED WARRANTY AND THE ONLY WARRANTY MADE BY VENDOR. VENDOR MAKES AND CLIENT RECEIVES NO OTHER WARRANTY EXPRESS OR IMPLIED AND ALL WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE ARE EXPRESSLY EXCLUDED. VENDOR SHALL HAVE NO LIABILITY WITH RESPECT TO ITS OBLIGATIONS UNDER THIS AGREEMENT FOR CONSEQUENTIAL, INCIDENTAL OR EXEMPLARY DAMAGES. THIS LIMITATION SHALL NOT WAIVE EITHER PARTY'S RIGHTS WITH RESPECT TO ANY WARRANTY, EXPRESS OR IMPLIED, GIVEN BY ANY PERSON OR ENTITY WHO OR WHICH IS NOT A PARTY TO THIS AGREEMENT.
- 9.8. Assignment. Neither party may assign its rights under this Agreement, except to an Affiliate, or the purchaser of substantially all of its assets. "Affiliate" shall mean any individual, corporation, partnership, association, or business that directly or indirectly controls or is controlled by, or is under common control with Client or Vendor, and in the case of Vendor, "Affiliate" shall also mean non-profit credentialing database company managed by Vendor.
- 9.9. Entire Agreement Modification. Neither party has been induced to enter into this Agreement by any written or oral statement or understanding not contained herein or incorporated by reference. All statements, undertakings,

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representations, warranties, agreements and other matters occurring between the parties and not reduced to writing herein are null and void. This Agreement may not be modified except by a written agreement executed by duly authorized representatives of both parties.

- 9.10. Binding Effect. Subject to the limitations herein above expressed, this Agreement shall inure to the benefit of and be binding upon the parties, their successors, and their assigns.
- 9.11. Governing Law and Jurisdiction. This Agreement shall be interpreted, construed, and governed by the laws of the state of Michigan, without regard to conflict of law principles. The parties agree to sole jurisdiction and venue in any Federal or State court sitting in _____ County in the State of Michigan.
- 9.12. Dispute Resolution. The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including, but not limited to, all questions of arbitrability, the existence, validity, scope or termination of this Agreement or any term thereof. If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see <http://www.adr.org>). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.
- 9.12.1. Any arbitration proceeding under this Agreement shall be conducted in Michigan. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.
- 9.12.2. The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because

MASTER SERVICES AGREEMENT

this Agreement affects interstate commerce the Federal Arbitration Act applies.

- 9.12.3. In the event that any portion of this Section or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Section or Agreement. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to punitive, exemplary, indirect or special damages.
- 9.12.4. In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration under Section 9.12. While such arbitration remains pending, the termination for breach will not take effect.
- 9.12.5. Remedies. Notwithstanding the provisions of 9.12, the parties acknowledge that great loss and immediate and irreparable injury would be suffered by a party if the other party should breach or violate any of the provisions of this Agreement pertaining to the privacy of individually identifiable health information (7.1), or confidentiality of business information (9.2) or employment of Vendor staff or contractors (3.8 of Exhibit "A"). All those provisions shall survive the termination of this Agreement. In addition to all of the remedies provided at law or in equity, each party may immediately seek a temporary restraining order and a permanent injunction to prevent a breach of any of such covenants or agreements without the necessity of posting bond, and will be entitled to payment of reasonable attorneys fees associated with pursuing those and other remedies.
- 10. Notices.** All notices required or permitted to be made or given hereunder shall be in writing, delivered by secure electronic mail, by hand or by facsimile, certified or registered mail, by overnight delivery by an established national delivery service at the respective addresses first set forth on the Cover Page attached hereto. All notices shall be deemed effective as follows: if by electronic mail, upon delivery, if by hand, upon personal delivery, if by facsimile, upon receipt, or if sent by certified

MASTER SERVICES AGREEMENT

or registered mail or by overnight delivery, when received. Notices shall be given as follows:

TO CLIENT:

TO VENDOR:

Outcomes, Inc.
1390 Stone Creek Lane, #303
Charlottesville, VA 22902
ATTN: Wanda Kochhar, Chairman
Fax: (434) 296-6297
E-Mail: wkochhar@outcomes.com

- 11. Force Majeure.** Neither party shall be liable for any failure or delay in the performance of its obligations due to fire, flood, earthquake, elements of nature or acts of God, acts of war, terrorism, riots, civil disorder, rebellions, or other similar cause beyond the reasonable control of the party affected, provided such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented, and provided further that the party hindered or delayed immediately notifies the other party describing the circumstances causing delay. Notwithstanding the foregoing, in the event that such condition prevents or delays performance of any party for a period in excess of thirty (30) days, the other party shall have the right to immediately terminate this Agreement upon written notice.
- 12. Insurance.** Vendor shall maintain general liability and employee dishonesty insurance policies or bonds in amounts and in forms standard and adequate for Vendor's business. Vendor shall provide proof of such insurance and shall immediately give written notice to Client in the event of any termination, cancellation, or material change in such insurance. Vendor may not cancel or modify such insurance without at least thirty (30) days written notice to Client.
- 13. Indemnification.** Both parties agree to indemnify, defend and hold harmless the other party, its directors, officers and employees from any claims, actions and suits

MASTER SERVICES AGREEMENT

(whether in contract or tort), and from any and all liabilities, losses, damages, costs, charges, penalties, counsel fees, settlement costs and other expenses of any nature incurred by either party, its directors, officers, or employees, as a result of any act or omission of the breaching party or its personnel, which is determined in a final judgment to have been the result of the breaching party's gross negligence or willful misconduct. This is the financial limitation of either party's liability hereunder. This Section does not affect any limitation on damages otherwise stated in this Agreement. In no event shall Vendor have any liability on account of incorrect information received from a third party or Client.

- 14. Notification of Change in Status.** If at any time during the term of this Agreement, the license, certification or other legal status of Vendor is suspended, revoked or restricted in any manner, Vendor will immediately notify Client in writing.
- 15. Term.** This Agreement shall become effective on the date signed below. It shall have a term of three (3) years. Negotiation of any changes in the terms and/or fee schedule set forth in any Exhibit will be completed no later than sixty (60) days prior to the end of each service year, unless terminated in accordance with the terms set forth below.
- 16. Termination Without Cause.** Either party may terminate this Agreement, with or without cause, by giving the other party ninety (90) days prior written notice. Client acknowledges that Vendor makes substantial investment in resources to execute its performance obligations under this Agreement and that Client's termination of this Agreement will have a material impact on Vendor's resource investments
- 17. Termination for Cause.** Either party may immediately terminate this Agreement for cause if the other is in material breach of any term, condition or provision of this Agreement, which breach is not cured within thirty (30) days after it receives written notice of such breach; or if the other party (i) terminates or suspends its business activities, (ii) becomes insolvent, admits in writing its inability to pay its debts as they mature, makes an assignment for the benefit of creditors, or becomes subject to direct control of a trustee, receiver or similar authority, (iii) files a voluntary petition in bankruptcy or seeks or consents to any reorganization or similar relief under any present or future bankruptcy act or similar law, or (iv) if a third party commences any bankruptcy, insolvency, reorganization or similar proceeding involving Vendor. If either party breaches any term of this Agreement and does not cure such breach, in accordance with the provisions of this Section, the other party shall have the right to terminate this Agreement immediately as well



MASTER SERVICES AGREEMENT

as all work then in process, and all amounts due and payable by either party under this Agreement will immediately become due and payable.

- 18. Headings.** Section headings used herein are provided for convenience of reference only and shall not constitute a part of this Agreement.
- 19. Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

The undersigned persons represent and warrant that we are legally free to enter this agreement and that our execution hereof has been duly authorized, and that upon both of our signatures below this shall be a binding agreement between Client and the other entities that are Client's affiliates and Vendor to the foregoing terms and conditions, and the terms of the attached exhibits.

CLIENT:

VENDOR:

OUTCOMES, INC.

Signature

Signature

Title

Title

Date

Date



MASTER SERVICES AGREEMENT

LIST OF EXHIBITS

EXHIBIT "A" – SCOPE OF WORK

EXHIBIT "B" – GLOSSARY

EXHIBIT "C" – 2005 HEDIS FEE SCHEDULE

EXHIBIT "D" – IMPLEMENTATION SCHEDULE

EXHIBIT "E" – REQUIRED DATA ELEMENTS AND FILE FORMATTING

EXHIBIT "F" – LIST OF CLIENT'S AFFILIATES



MASTER SERVICES AGREEMENT

EXHIBIT "A" SCOPE OF WORK

1. Vendor Services.

- 1.1 Vendor will provide Client with a copy of the evaluation procedures, review standards, and data capture systems it intends to use prior to providing services on behalf of Client. Client may request reasonable changes to the procedures, standards and data capture systems used by Vendor, but Client may be asked to pay additional fees to Vendor for customized work, or for additional work required as a result of a change in agreed upon standards and procedures which fees shall be agreed to by Client and Vendor in writing before any such services are provided.
- 1.2 For those charts assigned to Vendor, Vendor will perform all scheduling, chart retrieval, abstraction, data entry ODIS™ WebDE, IRR, and provider outreach for targeted measures for those charts/sites assigned to it by Client. (Member Outreach is optional but does require ODIS WebDE data entry.) Vendor will generate a file of all medical record events captured for hybrid members assigned to Vendor, in the pre-defined format, for data transfer to Client's third party software. This file will be available on-demand.
- 1.3 Vendor will provide Client with a copy of the evaluation procedures, review standards, and data capture systems it intends to use prior to providing services on behalf of Client. Client may request reasonable changes to the procedures, standards and data capture systems used by Vendor, but Client may be asked to pay additional fees to Vendor for customized work, or for additional work required as a result of a change in agreed upon standards and procedures which fees shall be agreed to by Client and Vendor in writing before any such services are provided.
- 1.4 Vendor will load the Client sample, schedule Services and conduct Services by qualified staff, perform reasonable inter-rater reliability to measure quality, data enter Services results in Vendor's licensed software ("ODIS™"), and provide Client with on-demand and end-of-project status reports.
- 1.5 Vendor will produce training materials appropriate for its services as described in this Agreement and any attachments hereto.

MASTER SERVICES AGREEMENT

- 1.6 Vendor will recruit, contract with, train, and supervise appropriately qualified personnel to perform the services described in this Agreement and any attachments hereto.
- 1.7 Vendor will conduct screenings on all individuals who will provide services on behalf of Vendor under this Agreement.

2 Scheduling and Conduct of Services.

- 2.1 Vendor shall contact Client's medical providers for the furtherance of Vendor's obligations hereunder, and will use its best efforts to insure that members and/or providers are contacted in a courteous and professional manner and otherwise in accordance with reasonable applicable instruction, if any, provided by Client to Vendor. Vendor and Client will mutually agree upon the contact and format of written member and provider communications.
- 2.2 Vendor will notify Client of any practitioner that cannot be reviewed and the reason that the review cannot be completed. Vendor will make three (3) attempts to locate and obtain access to records before reporting those records as unable to audit.
- 2.3 Vendor will pend all charts for which it is unable to audit no later than 24 hours of learning the chart is non-retrievable and assign the appropriate non-retrievable reason code to describe why the chart is non-retrievable. Vendor will provide Client web-enabled access for reviewing and terminating or reactivating pended charts. These records are defined as non-retrievable charts and are considered completed by the Vendor for purposes of performance guarantees and fees.

3 Client Responsibilities:

- 3.1 Client will pay Vendor for services described in the Scope of Work set forth herein, in accordance with the terms and conditions in Exhibit "C". Client shall be responsible for any fees, including copying charges, levied by any member of its provider network in conjunction with the services provided under the Agreement.
- 3.2 Client will provide to Vendor a complete listing of the members and health care facilities and practitioners in accordance with the required data elements and file structure set forth in Exhibit "E" and in accordance with the timelines set forth in Exhibit "D". Client shall provide Vendor complete and accurate information in a

MASTER SERVICES AGREEMENT

timely manner to enable Vendor to operate efficiently, minimize the intrusion on busy clinical practitioners and facilities, control costs for all Clients, and complete the project within the agreed upon timelines set forth in Exhibit "D". Client recognizes that incomplete or incorrect information will impair Vendor's ability to perform its obligations under this Agreement and Client agrees that all performance guarantees set forth in this Agreement will be nullified if Client fails to provide Vendor with complete and accurate information.

- 3.3 Client will deliver to Vendor an accurate and complete sample in accordance with the timeframes set forth in Exhibit "D", Implementation Schedule. If Client is unable to provide this information in accordance with the timeframes set forth in Exhibit "D", the deadline for Vendor to complete the abstractions for Client will be extended, such as to ensure that Vendor has no less than the agreed upon number of working days in accordance with Exhibit "D", (exclusive of weekends and holidays), to complete the work. Vendor may charge an additional fee of up to two hundred fifty dollars (\$250.00) per day of delay in the event that Client fails to comply with the timeframes set forth in Exhibit "D" and Vendor has less than the number of working days, set forth in Exhibit "D", to complete the project.
- 3.4 Client recognizes that Vendor bases its staffing and other resource planning on Client's volume projections. In the event Client requires fewer than eighty-five percent (85%) or more than one hundred and fifteen percent (115%) of its estimated chart volume set forth in Exhibit C, Vendor's resource planning to fulfill its obligations under this Agreement will be impacted and will result in additional charges to Client, and will nullify the Vendor performance guarantees in this Agreement. Client estimates should include rotation of measures, a realistic anticipated number of chart pursuits, and any state or federal regulatory requirements for Client's sample population.
- 3.5 If Client provides untimely, incomplete or inaccurate information, or makes changes to the information provided to Vendor such as to require Vendor to conduct additional work including, but not limited to, scheduling, recruiting/training, chart reviews, and/or data rework, additional charges will be applied in addition to charges for any initial visits made based on incomplete or inaccurate information. Such changes to information by Client may impact the delivery date for completed services since services cannot be adequately scheduled or conducted without accurate information, and may nullify Vendor performance guarantees.

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- 3.6 At least seven (7) calendar days prior to Vendor scheduling, Client will notify all providers in the sample of the process for HEDIS data collection, including Vendor's role, HIPAA, and chart copying requirements.
- 3.7 Client recognizes that circumstances beyond Vendor's control may result in a percentage of non-retrievable charts and/or site assessments including, but not limited to, non-responsive providers, provider refusals, uncooperative providers, unavailability of field reviewers resulting from Client's inaccurate estimate of chart volume or misinforming Vendor of provider locations in the sample, or late or inaccurate data supplied by Client resulting in less than the number of days set forth in Exhibit "D" to complete said late or inaccurate charts; provided, however, Vendor will make its best effort to retrieve all charts and perform all Services. Client also recognizes that Vendor will bill Client, and Client agrees to pay Vendor, for all charts and/or sites assessments, including non-retrievable charts and site assessments, in the Client sample as set forth in the fee schedule in Exhibit "C".
- 3.8 For a period of one year after the last date that Vendor provides services to Client pursuant to this Agreement, Client will not, directly or indirectly, recruit, solicit, employ, or enter into independent contractor relationships with any employee, independent contractor, or other representative of Vendor who provided any services to Client and will not assist any other party to recruit, employ or enter independent contractor relationships with such persons.

4 Performance Guarantees:

- 4.1 Vendor agrees to the following performance guarantees for timeliness:
- 4.1.1 **TIMELINESS GUARANTEE:** The agreed upon time frame is set forth in Exhibit "D". The timeframe shall begin upon the later of (i) Vendor acceptance of a final and complete sample, in the agreed upon format, OR (ii) Five (5) business days after Client has mailed letters to providers introducing Vendor.
- 4.1.2 Client may impose a penalty of one hundred dollars (\$100.00) per day in the event that Vendor fails to complete the project and provide completed final reports to Client in accordance with the timeframes provided in this Agreement in Exhibit "D". Completion of the project is defined as:
- 4.1.2.1 Loading the Client sample in preparation for scheduling. Client agrees that Client will submit sample in accordance with the timelines set

MASTER SERVICES AGREEMENT

forth in Exhibit "D" and in accordance with the agreed upon file format set forth in Exhibit "E".

- 4.1.2.2 Scheduling provider sites. Vendor will make up to three (3) attempts to retrieve charts within the timeframes set forth in Exhibit "D". Any charts not retrievable will be reported to Client and will include all dates of attempts, scheduling notes documenting the attempts, and reason codes for non-retrievable charts. Vendor makes no guarantees that all charts will be retrievable.
- 4.1.2.3 Site Assessments & Abstraction. Vendor will employ and train adequate staff to conduct site assessments and chart abstractions of retrieved charts within the timeframes set forth in Exhibit "D".
- 4.1.2.4 Data Entry. Vendor will employ and train adequate staff to ensure all data entry is complete. In addition, Vendor will make its reasonable best efforts to generate a medical record event file to be uploaded into Client's third party software.
- 4.1.2.5 Reporting. Vendor will make project status reports available, on-demand, to Client via www.my-odis.com.
- 4.1.3 Vendor and Client will have weekly conference calls to discuss progress and issues related to implementation of this Agreement.
- 4.1.4 To ensure a prompt response to urgent situations, both parties agree to use its reasonable best efforts to respond to telephone calls from the other party's appointed Project Manager within four (4) business hours of any call.
- 4.1.5 The performance guarantees described in this Section 4 will not apply if Vendor's inability to perform is due to circumstances beyond Vendor's control or due to the fault or delay of Client or Client's Practitioners or Facilities including, but not limited to, delays in providing clean data or accurate samples, scheduling changes or other changes required by Client not included in the implementation plan and the timeframes listed in Exhibit "D", provider refusals and non-cooperation and/or other restrictions on data collections, etc. As also provided in this Agreement, such penalties will not be applied in the event of a Force Majeure.

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**EXHIBIT "B"
GLOSSARY**

For purposes of this Agreement, the following definitions shall apply:

"Beneficiary" means a person who receives services under the terms of a health insurance program or health benefit plan administered by Client.

"De-Identified Information" means any and all information that cannot be used to identify an individual and shall expressly exclude the following identifying information: information that expressly identifies an individual, or which might be used to identify an individual (including the individual's name, address, relatives, employer, telephone or fax number, e-mail address, social security number, patient identification number, certificate or license number, web URL, IP address, finger and voice prints, photographic image or other unique identifying number); information that identifies the individual as a recipient of physical or mental health services or services for the treatment of alcohol or chemical dependency; or information that relates to the past, present or future physical or mental health or condition of an individual, or the past, present or future payment for the provision of health care services to an individual. De-Identified Information shall include, but not be limited to, an individual's sex, age, race, city and state of birth, zip code, diagnosis, lab values, drugs administered, test results and procedures.

"Facility" means a hospital, nursing home, clinic, or other licensed entity engaged in the delivery of medical and other health care services, but not a Practitioner or a practitioner's office.

"HIPAA" refers to the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations enacted or proposed to be enacted there under by the CLIENT States Department of Health and Human Services (Public Law 104-91, 42 U.S.C. 1301 et. seq.; regulations codified or to be codified at 45 CFR Part 142 and Parts 160 through 164).

"HEDIS[®]" refers to the Health Plan Employer Data and Information Set, published by the National Committee for Quality Assurance. HEDIS[®] is a set of standardized measures that specifies how health plans collect, audit and report on their performance in a number of clinical areas such as breast cancer screening, helping patients control their cholesterol, and management of diabetic patients. HEDIS[®] also includes measures of consumer satisfaction with health plan and medical services known as CAHPS[®].



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"HHS" means that the applicable State Department of Health and Human Services.

"Indicator" or "Indicators" means data identified by NCQA that is used to indicate whether clinical performance is consistent with national standards. Indicators are used to determine whether a HEDIS[®] Measure has been satisfied.

"Measure" or "Measures" means specific HEDIS[®] clinical performance measures, such as Childhood Immunization Status, Asthma Medication Management and others. A Measure includes a number of Indicators of clinical performance.

"Member" means the health plan Beneficiary identified in the sample for HEDIS[®] record reviews.

"NCQA" refers to the National Committee for Quality Assurance.

"Person" means any natural person, corporation, general partnership, limited partnership, limited liability company, limited liability partnership, proprietorship, trust, governmental authority, association or other entity, enterprise, authority or business.

"Practitioner" means a physician, psychologist, nurse, social worker, physical therapist or other clinical professional, or a group practice, professional association or other organization of clinical professionals.

"Query" refers to an attempt to locate and review a patient record for abstraction of clinical data, or for monitoring of record-keeping practices under credentialing or quality improvement operations.

"Record" means the physical or electronic patient chart as reviewed for the abstraction of clinical data, or for monitoring of record-keeping practices under credentialing or quality improvement operations.



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**EXHIBIT "C"
2006 HEDIS FEE SCHEDULE**

See Attached

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**EXHIBIT "D"
IMPLEMENTATION SCHEDULE**

Task	Due Date	Responsible Party
Confirm estimated Sample Size for HEDIS® 2006 & complete Implementation Plan	TBD	Client, Vendor
Client to send provider file (preferably list of providers from last year's HEDIS)	TBD	Client
Define Client Customization Requests (e.g., Tools, Reason Codes, Reports)	December 15, 2005	Client, Vendor
Sign Services Agreement, Make Deposit	December 15, 2005	Client, Vendor
Vendor will submit HEDIS® 2006 Training Manual to Client.	TBD	Client, Vendor
Complete BAT medical records sections relevant to Vendor	January 6, 2006	Vendor
Recruit, Train Additional Staff for HEDIS® 2006	Jan - Mar 2006	Vendor
Attend 3 rd party software training, if applicable	N/A	Vendor
Complete testing of MRR data exchange with 3 rd party software vendor (e.g., Catalyst)	March 1, 2006	Vendor
Confirm sample delivery date	TBD	Client
Client to submit test file for HEDIS sample	TBD	Client
Client delivers and vendor accepts final HEDIS® sample	TBD, but no later than 50 business days from the completion date	Client, Vendor
Integrate to Scheduling Program. Launch Scheduling.	Upon delivery of sample according to agreed upon specifications, complete 75% of scheduling within 3 weeks following Vendor acceptance of sample	Vendor
Abstract data, Conduct Quality Improvement/Inter-Rater Reliability Oversight, Report Data	50 business days from delivery and acceptance of sample according to agreed upon specifications	Vendor
Deliver Audit Samples of Selected Measures, Participate in Audit Reviews	TBD	Vendor, Client
Final Project Reports to Client	June 30, 2006, or 45 days after project completion, whichever is latest	Vendor
Review Performance, Evaluate and Set Performance Benchmarks for Best Practices	June 2006, or 45 days after project completion, whichever is latest	Vendor, Client
Decision to release or destroy the HEDIS Medical Records held by the Vendor	July 31, 2006	Client



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EXHIBIT "E"
REQUIRED DATA ELEMENTS AND FILE FORMATTING

The attached table, entitled ODIS Dictionary, identifies the required data elements and formatting of the Client sample and is made a part of this Agreement.



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EXHIBIT "F"
LIST OF CLIENT'S AFFILIATES

**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. 071B5200018
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084 RomanK@Molinahealthcare.com		TELEPHONE (248) 925-1710 Roman T. Kulich
		VENDOR NUMBER/MAIL CODE (004)
		BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 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 not the following changes:

1. Effective 6/28/05 the attached credentialing agreement with Henry Ford Health System is hereby incorporated into this contract.
2. Effective 6/23/05 the attached agreement with Michigan Peer Review Organization that includes Medicare Services is hereby incorporated into this contract.
3. Effective 7/6/05 the attached service agreement with PFM Management, LLC is hereby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and vendor contact (Michael Tegler).

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



MOLINA HEALTHCARE OF MICHIGAN

100 W. Big Beaver Road, Suite 600
Troy, Michigan 48061-7209
Toll Free 888-894-7869 or 248-925-1720
General Fax 248-925-1709
www.molinahealthcare.com

July 6, 2005

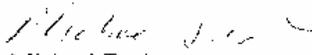
Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section I-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed service agreement with PFM Management LLC for your review.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,


Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget



Oct 31, 2002 - Dec 31, 2003

INVESTMENT ADVISORY AGREEMENT

THIS AGREEMENT, entered into as of the _____ day of July in the year of 2005, by and between MOLINA HEALTHCARE OF MICHIGAN, INC., Troy, Michigan (hereinafter "MHM"), and PFM ASSET MANAGEMENT LLC, a Delaware limited liability company with an office in Harrisburg, Pennsylvania, (hereinafter "PFM" or the "Investment Advisor").

WITNESSETH

WHEREAS, MHM has funds available for investment purposes (the "Investment Funds") for which it intends to conduct an investment program; and

WHEREAS, MHM desires to avail itself of the experience, sources of information, advice, assistance and facilities available to PFM; to have PFM undertake certain duties and responsibilities; and to perform certain services as investment advisor on behalf of MHM, as provided herein; and

WHEREAS, PFM is willing to provide such services on the terms and conditions hereinafter set forth;

NOW, THEREFORE, in consideration of the premises and mutual covenants herein contained, it is agreed as follows:

1. SERVICES OF ADVISOR.

PFM will provide investment management of the Investment Funds and such other funds as MHM may from time to time assign by written notice to PFM (collectively the "Managed Funds"). In connection therewith, PFM will provide investment research and supervision of MHM's Managed Funds investments and conduct a continuous program of investment, evaluation and, when appropriate, sale and reinvestment of MHM's Managed Funds assets. PFM shall continuously monitor investment opportunities and evaluate investments of MHM's Funds. PFM shall furnish MHM with statistical information and reports with respect to investments of the Managed Funds. PFM shall place all orders for the purchase, sale, loan or exchange of portfolio securities for MHM's account with brokers or dealers recommended by PFM and/or MHM, and to that end PFM is authorized as agent of MHM to give instructions to the depository designated by MHM as its custodian as to deliveries of securities and payments of cash for the

account of MHM. In connection with the selection of such brokers and dealers and the placing of such orders, PFM is directed to seek for MHM the most favorable execution and price, the determination of which may take into account, subject to any applicable laws, rules and regulations, whether statistical, research and other information or services have been or will be furnished to PFM by such brokers and dealers.

U.S. Bank National Association shall have custody of cash, assets and securities of MHM. PFM shall not take possession of or act as custodian for the cash, securities or other assets in the Managed Funds and shall have no responsibility in connection therewith except that PFM shall pay all fees of the custodian related to the Managed Funds. Authorized investments shall include only those investments which are currently authorized by the Investment Policy of MHM as dated February 17, 2005 and as supplemented by such other written instructions as may from time to time be provided by MHM to PFM. PFM shall be entitled to rely upon MHM'S written advice with respect to anticipated drawdowns of Managed Funds. PFM will observe the instructions of MHM with respect to broker/dealers who are approved to execute transactions involving MHM'S Managed Funds and in the absence of such instructions will engage broker/dealers which PFM reasonably believes to be reputable, qualified and financially sound.

2. COMPENSATION.

(a) As full compensation for services provided by PFM pursuant to this Agreement, MHM shall pay PFM an annual fee based on the daily net assets under management at an annual rate of 12 basis points (.12%) for the first \$25 million and 9 basis points (.09%) for assets in excess of \$25 million. The fee shall be computed daily and paid monthly.

Assets invested by PFM under terms of this Agreement may from time to time be invested in a money market mutual fund (a "Pool"), or in individual securities. Average daily net assets subject to the fees described in this paragraph shall not take into account any funds invested in the Pool. Expenses of the Pool, including compensation for PFM and the Pool custodian, are described in the relevant prospectus or information statement and are paid from the Pool.

(b) For the purposes of this Section, daily net assets under management shall include the aggregate of assets under management of MHM and any subsidiary of Molina Healthcare, Inc. that has assets which are being separately managed by PFM under the terms of an investment advisory agreement.

(c) PFM shall prepare an invoice for the investment management fee, set forth in subparagraph (a) above, and shall submit it to the MHM for approval. Unless instructed otherwise within 15 calendar days of the postmark on the invoice, MHM authorizes PFM to charge such invoice to MHM'S associated Pool account and instructs the Pool custodian to disburse funds from that account for the payment of the fees to PFM. If sufficient funds are not available, MHM agrees to compensate PFM and from other sources within 30 calendar days of the postmark date. If PFM shall serve for less than the whole month, the compensation shall be pro-rated.

(d) If and to the extent that MHM shall request PFM to render services other than those to be rendered by PFM hereunder, such additional services shall be compensated separately on terms to be agreed upon between PFM and MHM.

4. EXPENSES.

(a) PFM shall furnish at its own expense all necessary administrative services, office space, equipment, clerical personnel, telephone and other communication facilities, investment advisory facilities, expenses of the custodian of the Managed Funds and executive and supervisory personnel for managing the investments.

(b) Except as expressly provided otherwise herein, MHM shall pay all of its own expenses including, without limitation, taxes, commissions, fees and expenses of MHM'S independent auditors and legal counsel, if any, brokerage and other expenses connected with the execution of portfolio security transactions, insurance premiums and fees.

5. RESPONSIBILITY OF PFM.

PFM hereby represents it is a registered investment advisor under the Investment Advisers Act of 1940. PFM shall immediately notify MHM if at any time during the term of this Agreement it is not so registered or if its registration is suspended. PFM agrees to perform its duties and responsibilities under this Agreement with reasonable care.

6. CONFLICT OF INTEREST.

MHM understands that PFM performs investment advisory services for various other clients which may include investment companies and/or commingled trust funds. MHM agrees that PFM may give advice or take action with respect to any of its other clients which may differ from advice given or the timing or nature of action taken with respect to MHM 'S Managed Funds accounts, so long as it is the policy of PFM, to the extent practical, to allocate investment

opportunities to this account over a period of time on a fair and equitable basis relative to other clients. PFM shall not have any obligation to purchase, sell or exchange any security for MHM'S Managed Funds solely by reason of the fact that PFM, its principals, affiliates, or employees may purchase, sell or exchange such security for the account of any other client or for itself or its own accounts.

7. TERM.

This Agreement unless terminated sooner as set forth below, shall continue until December 31, 2005, and thereafter shall continue automatically from year to year.

This Agreement may be terminated by MHM in the event of any material breach of its terms immediately upon notice by certified mail, return receipt requested. This Agreement may be terminated by MHM, on not less than thirty (30) days written notice to PFM. PFM may terminate this Agreement immediately upon any material breach of its terms by MHM, or at any time after one year upon thirty (30) days written notice.

8. SUSPENSIONS, COMPLAINTS.

PFM shall promptly notify MHM in writing of any complaints or disciplinary actions filed against it, or any investment professional employed by it, who has performed any service with respect to MHM'S account in the 24 preceding months, by the Securities and Exchange Commission of the United States, the New York Stock Exchange, the American Stock Exchange, the National Association of Securities Dealers, any Attorney General or any regulatory agency or authority of any state of the United States, any department or agency or authority of the Government of the United States, or any governmental agency or authority regulating securities of any country in which PFM is doing business.

9. INDEPENDENT CONTRACTOR.

Except as described in Paragraph 1, PFM, its employees, officers and representatives, shall not be deemed to be employees, agents, partners, servants, and/or joint ventures of MHM by virtue of this Agreement or any actions or services rendered under this Agreement.

10. BOOKS.

PFM shall maintain appropriate records of all its activities hereunder. PFM shall provide MHM with a monthly statement showing deposits, withdrawals, purchases and sales (or maturities) of investments, earnings received, and the value of assets held on the last business day of the month. The statement shall be in the format and manner that is mutually agreed upon by PFM and MHM.

11. PFM'S DISCLOSURE STATEMENT.

PFM warrants that it has delivered to MHM, at least five business days prior to the execution of this Agreement, PFM's current Securities and Exchange Commission Form ADV, Part II (PFM's disclosure statement). MHM acknowledges receipt of such disclosure statement at least five business days prior to the execution of this Agreement.

12. MODIFICATION.

This Agreement shall not be changed, modified, terminated or discharged in whole or in part, except by an instrument in writing signed by both parties hereto, or their respective successors or assigns.

13. SUCCESSORS AND ASSIGNS.

The provisions of this Agreement shall be binding on PFM and its respective successors and assigns, provided, however, that the rights and obligations of PFM may not be assigned without the prior written consent of MHM.

14. APPLICABLE LAW.

This Agreement shall be construed, enforced, and administered according to the laws of the State of Michigan. PFM and MHM agree that, should a disagreement arise as to the terms or enforcement of any provision of this Agreement, each party will in good faith attempt to resolve said disagreement prior to filing a lawsuit.

15. VALIDITY.

The invalidity in whole or in part of any provision of this Agreement shall not void or affect the validity of any other provision.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their authorized representatives as of the date set forth in the first paragraph of this Agreement.

PFM ASSET MANAGEMENT LLC

By: _____

Title: _____

MOLINA HEALTH CARE OF MICHIGAN, INC.

By: _____

Title: _____



MOLINA HEALTHCARE OF MICHIGAN

100 W. Big Beaver Road, Suite 600
Troy, Michigan 48084-5209
Toll Free 888-898-7969 or 248-925-1700
General Fax 248-925-1709
www.molinahealthcare.com

June 23, 2005

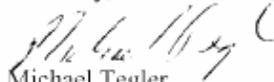
Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section 1-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed agreement with Michigan Peer Review Organization that includes Medicare Services in addition to Medicaid Services.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,


Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget ✓



Oct 24 2003 - Oct 24 2005

MEMORANDUM OF AGREEMENT
BETWEEN
MICHIGAN PEER REVIEW ORGANIZATION (MPRO)
AND
MOLINA HEALTHCARE OF MICHIGAN, INC. (MCO)

A. Parties

The parties to this agreement are the **Michigan Peer Review Organization**, hereinafter referred to as MPRO, and **Molina Healthcare of Michigan, Inc.** hereinafter referred to as MCO. MPRO is the federally designated Quality Improvement Organization (QIO) for the Centers for Medicare & Medicaid Services (CMS) in the state of Michigan. In all instances, both MPRO and the MCO are expected to know the terms of the agreement.

B. Statutory Specifications

Section 1154 (a)(1) of the Social Security Act (the Act) requires QIOs to review services furnished to Medicare beneficiaries by physicians, other health care professionals, providers and suppliers as specified in the contract with the Secretary.

Section 1154 (a)(4)(A) of the Act requires that a reasonable proportion of the QIO activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

Section 1154 (a)(14) of the Act requires that a QIO conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

Section 1852 (e)(3)(A) of the Act requires MCOs to maintain an agreement with the QIO to perform certain functions listed in §1866 (a)(3)(A).

Section 1866 (a)(3)(A) of the Act requires QIOs, under the MOA, to perform functions described under the third sentence in §1154 (a)(4)(A) related to quality of services and under §1154 (a)(14) related to beneficiary complaints.

II. QIO Program

In 1982, Congress established Utilization and Quality Control Peer Review Organizations (PROs), now known as QIOs, to perform two broad functions: (a) promote quality health care services for Medicare beneficiaries, and (b) determine whether services rendered are medically necessary, appropriate, and meet professionally recognized standards of care. The goal of the QIO program is to improve the processes and outcomes of care for Medicare beneficiaries. The QIO is to achieve this goal through performance of various directives promulgated by CMS in the QIO Contract, as discussed below.

Memorandum of Agreement for Providers

III. Purpose of Agreement

The purpose of this Agreement is to define the administrative relationship that will exist between parties in the exchange of data and information. This Memorandum of Agreement is required by the Medicare statute and regulations as well as the QIO manual and certain QIO contract directives. It is also intended to be informational. **MPRO** wants to inform Michigan MCOs of (a) **MPRO**'s procedures with respect to certain contract obligations, (b) review and appeal rights which providers have with respect to these obligations, and (c) opportunities providers have to collaborate with **MPRO** in local and national quality improvement projects.

IV. Effective Date

This Agreement shall be effective upon execution and shall remain in effect so long as **MPRO** is the Quality Improvement Organization, under contract with CMS, for the area in which the provider is located, or is terminated in accordance with Section VIII of this Agreement or the provider withdraws or is terminated from the Medicare program.

V. Confidentiality

Confidentiality and disclosure shall be determined as set forth by applicable federal QIO confidentiality regulations (42 CFR 480.103). **MPRO**'s Medicare data collection, and disclosure policies and procedures shall conform to all applicable federal laws. In addition, **MPRO** shall take reasonable measures to inform patients, practitioners, providers, and others about the rules governing disclosure of confidential information. These measures shall include, but are not limited to, sponsoring general educational efforts and providing a disclosure statement in all material written that includes this information. **MPRO** shall print the following written statement on all pages of all disclosures of confidential information, and corollary confidentiality policies and procedures:

This document, provided to you by MPRO, contains confidential information. Federal Regulations generally prohibit your disclosure of this information to any other party. A violation of these regulations may result in a fine and/or imprisonment. (42CFR480.107, 42CFR480.108)

Note: An institution may disclose information pertaining to it provided it does not identify an individual patient or practitioner.

MPRO will abide by the applicable federal confidentiality laws and regulations (including HIPAA) in §1160 of the Act and 42 CFR, Part 480. **MPRO** recognizes the inherent right of the individual to privacy and at the same time acknowledges the medical profession's need for adequate information in order to carry out its activities under this Agreement. To protect the confidentiality of data acquired by **MPRO** in carrying out its responsibilities under this contract, **MPRO** shall be bound by §1160 of the Act and applicable regulations. **MPRO** shall ensure the confidentiality and security of the **MCO** medical records and data from the time the medical records/data are acquired by **MPRO** until their destruction in accordance with the statute and regulations.

Memorandum of Agreement for Providers

The MCO shall adhere to the applicable state and federal laws, which protect the confidentiality of medical review information.

VI. Conflict of Interest

MPRO shall at all times demonstrate its complete objectivity and independence. No actual, potential, or apparent conflict of interest with respect to its obligations under this MOA shall be permitted.

MPRO may contract and/or develop a business arrangement with MCO to provide services only to the extent that such contracts are not similar to or duplicate work which MPRO has contracted to perform for CMS in support of Medicare beneficiaries. The contract or arrangement may be similar in scope to the work performed under the Medicare contract if the type of work that MPRO will perform involves a non-Medicare population.

If M+CO desires to engage MPRO for services that are permitted by CMS, a separate Agreement shall be developed between MCO and MPRO. The Agreement shall describe the services to be provided, fee for such services, and contain a provider acknowledgment statement.

MPRO shall at all times be in compliance with any and all applicable state and federal conflict of interest requirements to which it may be subject and shall abide by any determination by CMS, Department of Health and Human Services (DHHS), and/or any judicial or quasi judicial body in this regard.

VII. Provisions of Agreement

Memorandum of Agreements (MOA) with MCOs reflect QIO review responsibilities referenced in §1866 (a)(3)(A), §1154 (a)(4)(A) and §1154 (a)(14) of the Act as well as the responsibilities of each provider regarding activities contained within that Scope of Work (SOW). (See sections 3015 and 3020 of the QIO Manual.)

A reasonable proportion of QIO activities are involved in reviewing, under §1154 (a)(I)(B) of the Act, the quality of services and that a reasonable allocation of these activities be made among different settings. In addition, §1154 (a)(14) of the Act requires that QIOs conduct an appropriate review of written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

In addition, MPRO agrees that it will assume responsibility for performing the following activities mentioned in the SOW for Medicare. The list of MPRO responsibilities in the area below is not all inclusive. Many of the activities are provided in the SOW, which changes with each three-year QIO/CMS contract period.

A. MPRO Responsibilities

MPRO shall assume the federally mandated responsibility for performing the following

Memorandum of Agreement for Providers

activities for Title XVII (Medicare):

1. Health Care Quality Improvement projects are collaborative efforts with healthcare providers and other groups which result in measurable improvement of processes and outcomes of care for Medicare beneficiaries. The goal is to make measurable improvements in Medicare beneficiary health status or satisfaction. MPRO is required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers to improve the processes of care by further reducing the variations and enhancing the results.

MPRO will support statewide/regional/local quality improvement activities by acting as a convener, facilitator and/or clearinghouse for the required QAPI projects not supported by other MPRO activities.

2. Communication Activities will be provided which result in information for education of health care providers, beneficiaries, and others to improve quality of care and to promote early detection and prevention of disease.

MPRO shall conduct educational programs to disseminate pertinent findings from national, state, local cooperative improvement projects, and other issues affecting the MCO community.

Beneficiary Rights Outreach & Education Activities will be conducted to inform Medicare enrollees about QIO review programs, the role of the QIO, and grievance and complaint procedures.

3. Mandatory Case Review involves non-physician screening and physician-review of medical records which require review under the SOW. Mandatory case review for MCOs involves review of all written beneficiary complaints MPRO receives relative to the quality of care provided to a Medicare beneficiary, Health Plan Issued Notices of Discharge and Medicare Appeal Rights (NODMAR), Fast track appeals, potential concerns identified during project data collection, and referrals from CMS and the OIG. This is accomplished by the review procedure specified in the QIO Manual, Parts 4 & 5. This manual can be accessed at <http://cms.hhs.gov/manuals/19pro/pr00.asp>

MPRO will respond to all written complaints from Medicare beneficiaries enrolled in the MCO concerning services provided in or by M+CO affiliated hospitals, ambulatory surgery centers, skilled nursing facilities, hospital outpatient areas, emergency rooms and physician. The MCO will be given 30-days to provide the medical records to MPRO, if any such records are in its possession. If such records are not in M+CO's possession, MCO will provide MPRO with the office (or clinic) data so that MPRO may procure medical records directly from the health provider who rendered the service that is the subject of the complaint.

Complaint analysis will be conducted in response to written beneficiary complaints about the quality of services received. MPRO will conduct a review of all written complaints received from a Medicare beneficiary or the beneficiary's representative. MPRO does not review non-

Memorandum of Agreement for Providers

medical issues, but rather, refers them to the appropriate entity or to the CMS Regional Office for coordination. Review findings on the M+CO may be disclosed to the beneficiary, but physician issues cannot be disclosed without the consent of the physician. Both the physician and the MCO are given an opportunity to respond to the review findings prior to the release of the review results to the beneficiary.

Where quality concerns are identified, MPRO will work with the provider to develop, implement, and complete corrective action plans or process improvement plans to address confirmed quality concerns or patterns of quality problems. Details are available in the QIO Manual.

A request by MPRO for MCO medical records in connection with a Medicare review, where M+CO has such records in its possession, shall be clearly identifiable as such and shall be easily distinguished on its face from requests by MPRO under other agreements. Such request shall also identify the purpose for which the case was selected. MCO agrees to provide the medical record when requested.

MPRO will reimburse MCO for costs incurred at the applicable federal photocopying reimbursement rate, plus actual first-class mailing costs. MPRO agrees to reimburse MCO for cost incurred in furnishing additional copies (those requested a second or subsequent time) at the federal reimbursement level.

MPRO shall conduct Medicare medical reviews in such manner, in such locations, and within such time frames as are set forth in applicable federal laws and regulation, the SOW, the contract between CMS and MPRO, the interpretive rules of the Department of Health and Human Services, and the MOA. At the MCO's request, MPRO will discuss its Medicare contract, processes, and/or screening criteria with MCO and MCO's medical staff representatives.

MPRO will only use licensed doctors of medicine, osteopathy, dentistry, podiatric medicine, or optometry to review and make final determinations about services rendered by their respective peers practicing in the same setting. Whenever possible, determinations should be made by a direct peer of the practitioner being reviewed.

To the greatest extent possible, all physician-reviewers who are doctors of medicine or osteopathy should be certified by specialty boards recognized by the American Board of Medical Specialties or by a specialty board under the auspices of the American Osteopathic Association. The physician-reviewer's specialty and practice setting should be the same as that of the physician under review. Only when it is not possible to match the specialty, e.g. a conflict of interest exists, may MPRO utilize a physician who is not a specialist in the type of services under review to make a final determination. When it is not possible to match the physician's practice setting, a physician-reviewer who practices in a different setting may be used. A match in specialty is considered a priority over a match in practice setting.

At any time in the review process and upon MCO's request, MPRO shall disclose the reviewing physician's specialty. All final adverse determinations shall specify the reviewing

Memorandum of Agreement for Providers

physician's specialty.

In order to permit orderly implementation of any changes in the SOW, process, or screening criteria, MPRO will notify the M+CO of such changes no less than thirty (30) days prior to implementation, unless CMS directives preclude such notification. MPRO will use its best efforts to provide MCO the full thirty (30) days advance notice of changes. If thirty (30) days advance notice is not possible due to CMS actions, MPRO shall notify MCO of changes as soon as possible, but in no event later than thirty (30) days after notice to MPRO of such changes. MPRO will utilize Administrative Memoranda addressed to the Administrator and copied to the MCO-designated MPRO liaison to transmit such notice.

B. MCO Responsibilities

MCO agrees to notify MPRO, in writing, of changes in contract-specified contact persons, ownership, or change in Medicare certification status.

The list of provider responsibilities in the areas below is not all inclusive. Many of the provider activities in the SOW change with each three-year QIO/CMS contract period.

The MCO shall submit medical records and other information to the QIO which are needed to conduct off-site review and cooperative project activities.

The MCO will adhere to applicable federal laws (including HIPAA), regulations and guidelines that protect the confidentiality of medical review information, as well as applicable state laws and regulations.

The MCO may, as part of participation in health care quality improvement projects, request technical assistance from the QIO or accept technical assistance offered by the QIO.

VIII. Modification of Agreement

This Agreement may be amended by MPRO at any time as necessary to conform with any changes or modifications to relevant state or federal laws or applicable regulations, CMS transmittals, program directives, or instructions issued pursuant to applicable laws and regulations. In the event of such an amendment, MPRO shall provide the MCO with notice of any such new or revised laws, regulations, CMS transmittals, program directives, or instructions, etc.

IX. Termination of Agreement

This Agreement may be terminated, upon advance written notice by one party to the other, as follows:

- A. By the MCO without cause with 60-day prior written notice to MPRO if the M+CO determines that it is no longer required to be a party to this Agreement as a condition of participation in the Medicare program.

Memorandum of Agreement for Providers

B. In the event that the **MPRO** status as a QIO and/or the **MCO** status, as an institution qualified and eligible to receive reimbursement for services and items provided under the Medicare program, is terminated by CMS. In the event that CMS terminates this Agreement, **MPRO** shall notify MCO of termination.

C. In the event that the QIO and the provider cannot agree to a modification to the Agreement, and MPRO will notify CMS.

X. Miscellaneous Provisions

A. Severability:

Should any clause, portion, or section of this Agreement be unenforceable or invalid, this shall not affect the enforceability or validity of the remainder of this Agreement. Should any particular provision(s) of this Agreement be held unreasonable or unenforceable for any reason, the provisions shall be given effect and enforced to whatever extent would be reasonable and enforceable.

B. Governing Law:

To the extent procedures for resolving any dispute under this Agreement are not available through the Department of Health and Human Services, this Agreement and any disputes arising under it shall be governed by laws of the state of Michigan.

C. Resolution of Disputes:

If problems in the parties' relationship present themselves, or in the event a dispute arises between the parties, the parties shall attempt to resolve those differences in good faith. If a good faith dispute resolution should fail **MPRO** shall notify CMS, and CMS shall advise the parties concerning the matter in dispute.

D. Notices:

Notice from **MPRO** concerning this Agreement shall be directed to the party specified on the signature page below. Other notices from **MPRO**, which are issued as a result of activities required by this Agreement, shall be directed to an individual designated by the **MCO**. **MCO** is responsible for notifying **MPRO** about any change in the person designated to receive such communications.

Notices from the **MCO** in response to **MPRO** notices shall be directed to the individual or department specified in **MPRO** communications.

E. Change of Ownership:

In the event of a change of ownership, the new owners will assume all obligations in the current

Memorandum of Agreement for Providers

MOA.

Agreement To Terms

The undersigned acknowledge that this Agreement is made pursuant to §1866 (a)(1)(F)(i), §1866(a)(1)(F)(ii) and §1852 (e)(3)(A) of the Act, 42 CFR, Part 476; the QIO Manual and certain QIO contract directives, and agree to abide by the terms and conditions set forth.

Health Plan Name: MOLINA HEALTHCARE OF MICHIGAN, INC.

Address: 100 W. BIG BEAVER ROAD, SUITE 600, TROY, MI 48084

Signature of Health Plan Administrator: _____

Date: _____

Name, address and title of individual (QIO) executing Agreement:

Debra Moss, MD, MBA, President/CEO

MPRO

22670 Haggerty Road

Suite 100

Farmington Hills, MI 48335-2611

Signature:

Debra Moss, MD, MBA
President/CEO

Date: _____

Memorandum of Agreement for Providers

M+C CONTACT FORM

To ensure that contact is made with the correct person at your facility, please complete all fields.

CEO/ADMINISTRATOR: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____	MEDICAL RECORDS CONTACT: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____
MPRO LIAISON: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____	MEDICAL DIRECTOR: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____
HCQIP CONTACT: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____	INFORMATION TECHNOLOGY CONTACT: _____ _____ TITLE: _____ _____ PHONE: _____ FAX: _____ E-MAIL: _____ _____

MPRO liaison: Person in your facility who will be the contact with MPRO staff. This person will receive all correspondence related to your facility. This correspondence includes: adverse determinations, approvals, Administrative memoranda, policy changes.

HCQIP contact: The person in your facility who will work closely with the Health Care Quality Improvement Project Manager at MPRO.

Medical Records Contact: The provider designee for whom all requests for medical records should go to.

Medical Director: The medical director for your facility.

Memorandum of Agreement for Providers

Information Technology Contact: The provider designee for which concerns regarding information technology can be directed by MPRO's information technology staff.

**PLEASE RETURN THE SIGNATURE PAGE
AND THE HOSPITAL CONTACT FORM
WITHIN 30 DAYS.**



MOLINA HEALTHCARE OF MICHIGAN

100 W. Big Beaver Road, Suite 600
Troy, Michigan 48084-5209
Toll Free 888-898-7969 or 248-925-1700
General Fax 248-925-1709
www.molinahealthcare.com

June 28, 2005

Julie Blazic
State of Michigan
Medical Services Administration
Department of Community Health
400 S. Pine, 7th Floor
Lansing, MI 48913

Dear Ms. Blazic:

Pursuant to Section 1-W of Medicaid Contract #071B5200018 between The State of Michigan and Molina Healthcare of Michigan, Inc., I have enclosed a proposed delegated credentialing agreement with Henry Ford Health System for your review.

Please contact me at (248) 925-1720 should you have any questions.

Sincerely,


Michael Tegler
Chief Financial Officer

Cc:

Irene Pena, Department of Management and Budget 



Oct 24 2003 - Oct 24 2005



HENRY FORD HEALTH SYSTEM DELEGATED CREDENTIALING AGREEMENT

This delegated credentialing agreement ("Agreement"), is effective as of _____ ("Effective Date"), by and between Henry Ford Health System (HFHS) and _____ (MOLINA HEALTHCARE OF MICHIGAN).

Whereas, HFHS is a non-profit corporation duly licensed and existing under and pursuant to the laws of the State of Michigan; and

Whereas, MOLINA HEALTHCARE OF MICHIGAN has the responsibility to assure that its contracted providers meet applicable licensure and/or certification requirements for credentialing purposes as mandated by law; and

Whereas, HFHS is a legal entity furnishing health care services by health care professionals; and

Whereas, HFHS wishes to assume responsibility for the credentialing and periodic recredentialing process of its health care professionals; and

Whereas, HFHS and MOLINA HEALTHCARE OF MICHIGAN share the common goal of offering quality health care services to their customers; and

Whereas, MOLINA HEALTHCARE OF MICHIGAN has reviewed HFHS's credentialing policy, recredentialing policy and staff application and find them to be equal or greater in scope than those of MOLINA HEALTHCARE OF MICHIGAN.

NOW THEREFORE, in consideration of the mutual promises, terms and conditions contained herein, the parties agree as follows:

I. HFHS RESPONSIBILITIES

- A. HFHS shall perform all credentialing and recredentialing of its health care professionals substantially in accordance with applicable state and federal laws, regulations and accreditation standards and will maintain current and complete files at all times.

- B. HFHS shall submit to MOLINA HEALTHCARE OF MICHIGAN a profile, in a format mutually agreed upon by MOLINA HEALTHCARE OF MICHIGAN and HFHS, for each health care professional upon initial credentialing and recredentialing containing at a minimum, the following information:
1. Name and degree
 2. Primary office address and phone number
 3. Date of birth
 4. Medical education including internship residency, and fellowship (if applicable)
 5. State license number and expiration date
 6. DEA number and expiration date
 7. Board and subspecialty certification with certification date and expiration
 8. Approved areas of specialty
 9. Appointment date
- C. Subject to applicable state and federal confidentiality laws including peer review laws, HFHS agrees to auditing of files by MOLINA HEALTHCARE OF MICHIGAN, at mutually agreed upon times, once a year, not to exceed 5% of total files or a maximum of twenty-five (25) files or NCQA requirements whichever is less.
- D. HFHS shall permit access to credentialing files by the Michigan Department of Community Health, the National Committee for Quality Assurance, or any applicable state or federal regulatory body.
- E. HFHS shall maintain at HFHS's expense, adequate insurance for general and professional liability coverage or an equivalent program of self-insurance, consistent with the community standards for the type of facility and level of care provided or such additional coverage as is required by law. HFHS shall give MOLINA HEALTHCARE OF MICHIGAN proof of insurance evidencing the coverage described herein upon request.
- F. HFHS shall make best efforts to notify MOLINA HEALTHCARE OF MICHIGAN of material changes in status, addition of health care professionals, or termination of health care professionals every thirty (30) days.

II. MOLINA HEALTHCARE OF MICHIGAN RESPONSIBILITIES

- A. MOLINA HEALTHCARE OF MICHIGAN has the right to approve provider sites; and upon mutual agreement between MOLINA HEALTHCARE OF MICHIGAN and HFHS, to reject, terminate or suspend individual health care professionals from providing services to MOLINA HEALTHCARE OF MICHIGAN members.
- B. MOLINA HEALTHCARE OF MICHIGAN shall remit payment to HFHS for delegated credentialing services according to cost schedule in Section V of this Agreement.

III. MISCELLANEOUS

- A. Both parties agree that all information concerning individual health care professionals and credentialing decisions made by MOLINA HEALTHCARE OF MICHIGAN, are to be treated as strictly confidential consistent with applicable law, and may not be disclosed to any third party without express written consent from the health care professional or as otherwise provided by law.
- B. The parties hereto mutually agree to indemnify and to hold each other (including officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party, including reasonable attorneys' fees, arising out of or in connection with, whether directly or indirectly, the performance of any service, or any other act or omission by or under the direction of the indemnifying party or its employees or agents.
- C. Neither party may assign this Agreement without the prior written approval of the other party.
- D. This Agreement constitutes the entire credentialing agreement of the parties and supersedes all prior negotiations, oral understandings or statements of intent. Any subsequent modifications or amendments to this Agreement must be in writing and signed by both parties.
- E. This Agreement shall be governed by and construed in accordance with the State of Michigan.

IV. TERM AND TERMINATION

The term of this Agreement shall become effective on _____ and shall expire at the same time the MOLINA HEALTHCARE OF MICHIGAN Provider Agreement expires or terminates.

V. COST SCHEDULE

HFHS and MOLINA HEALTHCARE OF MICHIGAN agree to the following cost schedule for Henry Ford Health System to assume the responsibility of Delegated Credentialing and Recredentialing for the Henry Ford Medical Group (employed physicians). Henry Ford Medical Group Delegated Credentialing services meet all NCQA and JCAHO accreditation.

1. Delegated Credentialing Cost Schedule

(A) Primary Verification

SERVICES	SOURCES	COST
Application	Collection of : <ul style="list-style-type: none"> • Collection of : Education certificates (advanced degree, medical school, internship, residency and fellowship) • Proof of board certification/eligibility • References • Past employment (including privileges at other facilities) • Licensor • Proof of malpractice • Curriculum vitae (CV) • Immigration status 	Per physician
Verification	Primary Source <ul style="list-style-type: none"> • Education (written and /or phone verification including ECFMG, AMA profile) • Board Certification (ABMS, AOA, and on-line sources) • Licensure (CIS, Internet, AMA profile, National Practitioner Data Bank) • Malpractice (written) • Immigration status • References 	\$15.00

(B) Secondary Verification

Privileging	Primary Source collection and verification experience/qualifications.	
Recredentialing	Meets NCQA/JCAHO requirements (Every two (2) years)	\$10.00

Primary Verification will require an initial payment of \$ 15.00 per physician (based on _____ physicians) credentialed for participation with MOLINA

HEALTHCARE OF MICHIGAN. A Payment of _____ will be expected at the time the Agreement is executed.

Secondary Verification will occur every two (2) years for which Henry Ford Health System will bill MOLINA HEALTHCARE OF MICHIGAN in annual increments of \$5.00 per physician. MOLINA HEALTHCARE OF MICHIGAN shall be billed upon each anniversary date of the Medical Services Agreement and payment shall be due within thirty (30) days of receipt of the billing statement.

All credentialing payments should be made to the following address:

**Henry Ford Health System
Managed Care Contracting
1 Ford Place, 5F
Detroit, MI 48202
ATTN: Manager**

MOLINA HEALTHCARE OF MICHIGAN
(Payor)

HENRY FORD HEALTH SYSTEM
(Provider)

By: _____

By: _____

Title: _____

Title: _____

Date: _____

Date: _____

Mike Tegler

From: Myers, Marn G [Marn_Myers@JudsonCenter.org]

Sent: Monday, June 27, 2005 5:36 PM

To: Zimmerman Brad; Anderson Benjamin L.; Andrus' assistant - Katherine Fox; Andrus, Gary - work; Aubrey John; Bayson, Jim; Bertapelle, Angelo; Bolden, Curt; Drew Dale; Elliott, Maureen; Farago, Peter; Hailey, J. M.; Hamilton, George; Hamilton's assistant - Linda Lauzon; Harper, Bill; Hauberg Kyle; Heisel, Mike; Henes, Steve; Hill, Peter K.; Kaye, Jim; LaNeve, Mark R.; LaNeve's assistant - Jill Sager; Lau, David; Lau's assistant - Sharon; Lett, Dr. Philip; Logan Anne M.; Miidrag, George; Mills S. Jay; Mistele, Henry; Poe, Jim; Savoie, Mike; Schlesinger, E. M.; Steward, Larry; Steward's assistant - Sue Hunsanger; Mike Tegler; Vanek, Gary; Vines' assistant - Sandy; Vines, Jason; Visperas Olivia; Williams, Doug; Williams, Pat; Zimmer, David; Exec-Team-DL

Subject: A Challenge

Good Afternoon, Everyone!

I am writing to share with you that our Wayne regional office in Redford was involved in a fire this weekend. The good news is that no one was there, and therefore, no one was hurt. The more extensive damage was at the far end of the building. Although, I have not been in the building yet, Jeremy Gilliam, the principal of the charter school planning to use the building, has shared with me that our area was the least damaged. He described our area as having smoke damage and soot on equipment. In that there is no electricity or water in the building, they expect it will be at least 2 weeks before we can be back in operation there.

In the mean time, thanks to the leadership of Sean deFour, Aubrey Macfarlane-Baranowski, and Robin Johnson, we have Wayne county staff working out of the Royal Oak, Washtenaw, and Macomb County offices. When you run into the unexpected like this, you really find what your staff are like. I can tell you that I am extremely proud of how in spite of the inconvenience, each and everyone has taken care of the business at hand. I am also grateful for the staff who at the other offices have made space available and are sharing resources. Our receptionist at the Royal Oak office has gone above and beyond to accommodate this situation, as has our MIS team and many others.

At this time, we have a plan and are working the plan. I just wanted to update you in case, you had seen this on the news this weekend.

Sincerely,

Marn G. Myers
President & CEO

Judson Center
4410 West Thirteen Mile Road
Royal Oak, MI 48073-6515

(248) 837-2002

MAHP ANALYSIS OF CURRENT LEGISLATIVE ACTION ON MEDICAID BUDGET

Budget Issue/MAHP Position	Executive	House	Senate
Overall Gross DCH Appropriations	\$10,240,883,200	\$9,878,814,600	\$10,017,557,500
<p>Overall Health Plan Line Item Gross Appropriations</p> <p>(MAHP believes the Executive Proposal is close—assuming no other changes in program (benefit/eligibility, etc)—however base is probably light due to caseload beginning in FY 05 and transfers making up difference this year.</p> <p>In all instances, there is no change proposed from current FY 05 Rates.</p>	<p>\$1,890,668,400 (Executive Proposal assumes no other changes and may be light due to increased caseload taking place in FY 05)</p>	<p>\$1,658,116,200 (House proposal assumes reductions related to elimination of Caretaker Relative, etc.—caseload assumptions may be light also as mentioned already</p>	<p>\$2,012,044,000 (Senate Version, transfers line item funding of GME to Health Plan line accounting for major difference from Executive)</p>

MAHP ANALYSIS OF CURRENT LEGISLATIVE ACTION ON MEDICAID BUDGET

<p>Actuarial Soundness</p> <p>MAHP supports House Version</p>	<p>Executive Assumes no additional funding for 2nd year of rates—seeking waiver to exempt responsibility.</p>	<p>House proposed language to assure that health plans are paid actuarially sound based on plan (MAHP White Paper) which reduces the cost of the program through policy, administrative and other changes (Section 1700).</p>	<p>Senate recognizes there is no funding for 2nd year of rate and does provide some additional flexibility to reduce costs.</p>
<p>Observation Policy</p> <p>MAHP would support House Version</p>	<p>Not addressed</p>	<p>House requires DCH to develop a policy for a rate to cover observation stays (Section 1711 (3))</p>	<p>Senate did not address.</p>
<p>Co-Payments</p> <p>MAHP has supported non-emergency use co-pay of \$25 and copay on non-generics –MAHP is opposed to copay in physician office and is open to discussion on others (issue of collections)</p>	<p>Addressed in Super Waiver application (1115)</p>	<p>House Proposes co-payments for Physician Visits (\$7.6 M in Gross savings) (Section 1631)</p>	<p>Senate proposes copayments that in total save \$39 M (gross in FFS program):</p> <ul style="list-style-type: none"> --\$10 for brand name Rx --\$25 for emergency room --\$10 for hospital outpatient service and physician visit --1st day of hospital admission of \$25 --copay on DME (tbd) --copay on non-emergency transportation (tbd)
<p>Benefit Modifications</p> <p>MAHP has supported developing modified benefit packages for all populations, including Medicaid based upon ability to support benefit package.</p>	<p>Addressed in Medicaid 1115 waiver for selected optional populations--</p>	<p>House did not support the benefit modification – instead eliminated categories of enrollment</p>	<p>Senate generally agreed with modifications—except for Prescriptions.</p>

MAHP ANALYSIS OF CURRENT LEGISLATIVE ACTION ON MEDICAID BUDGET

<p>GME Flow Through Plans</p> <p>MAHP supports Senate Version (language) but House level of funding - restores GME cut. MAHP would suggest using EFT and flow health plan funds to MAHP Foundation who (under agreement with plans) would fund each of the Hospital GME programs - again using EFT.</p>	<p>Language to permit this is included again—Executive proposed GME flow through in FY '05 budget.</p>	<p>House permits the flow through similar to Senate</p>	<p>Senate moves dollars to health plan line, however, boilerplate would revert to Hospital line item if cannot agree on spending authority.</p>
<p>MI-CHILD</p> <p>MAHP Supports House version of language. Would increase total premiums to health plans by about \$30 million that are currently paid now to BCBSM.</p>	<p>Status Quo—However, Executive proposed moving to Medicaid HMOs in FY 05 budget.</p>	<p>House restricts funding to only Medicaid HMOs—where HMOs have service area. While funding remains in MI CHILD line—would be used to pay health plans based on existing rates. \$78.63/PMPM</p>	<p>Senate restricts to Medicaid HMOs and moves funding to Health Plan line item. Assumes funding at current rate to plans-- \$78.63.</p>
<p>Healthy Michigan Funds</p> <p>MAHP supports the House Version. Would be administered similar to Adolescent Center Program— but use MAHP Foundation.</p>	<p>Executive proposes to shift \$1.2 million of HMF to Medicaid to support base and save \$1.2 M in GF</p>	<p>The House eliminates \$8.9 M of HMF and moves dollars to Medicaid Base and moves \$10.4 million to the Health Plan line item to support HMF for Medicaid enrollees.</p>	<p>The Senate eliminates \$9.3 million in funding that was added in FY 05.</p>
<p>Eligibility—19-20 year olds</p> <p>MAHP would support the Senate Version.</p>	<p>Executive Budget proposes Super Waiver (1115) to freeze enrollment and gradually eliminate thru attrition.</p>	<p>House proposes to save \$27 million (gross) by eliminating this category</p>	<p>Same as Executive</p>

MAHP ANALYSIS OF CURRENT LEGISLATIVE ACTION ON MEDICAID BUDGET

<p>Eligibility—Caretaker Relative MAHP would support the Executive.</p>	<p>Executive Budget proposes Super Waiver (1115) to modify benefits for Care Taker Relative.</p>	<p>House proposes to eliminate Caretaker Relative and save \$98 million (gross).</p>	<p>Senate proposes to freeze enrollment and modify benefits as Executive but does not agree on pharmacy limitation</p>
<p>Eligibility—Adult Benefit waiver MAHP has no position</p>	<p>Status Quo with modification in Super Waiver..</p>	<p>House proposes to freeze enrollment and save \$19 M (Gross)</p>	<p>Senate proposes freeze Adult benefit waiver and saving \$28.3 M (gross).</p>
<p>Medicaid Premium for Beneficiaries-- MAHP has no position of this issue -- question of operational issues</p>	<p>Not addressed</p>	<p>House proposes a new \$5 Medicaid premium to generate \$17.4 million gross savings</p>	<p>Senate proposes a new \$5 premium that would be reduced with completion of patient responsibility plan. Savings of about \$36 M in savings.</p>
<p>Disease Management Options MAHP would support disease management options for other populations not enrolled in Medicaid Contract.</p>	<p>Not addressed</p>	<p>Not specifically addressed other than new Section 1700 as a tool for reaching actuarially sound rates.</p>	<p>Not addressed</p>
<p>School based Clinics & Michigan Model (education) MAHP Supports</p>	<p>Continues funding of School based clinics and Michigan Model funding as match for the Adolescent Center program funded by Medicaid HMOs</p>	<p>Same as Executive</p>	<p>Same as Executive</p>

MAHP ANALYSIS OF CURRENT LEGISLATIVE ACTION ON MEDICAID BUDGET

<p>One-Third Share Program MAHP has no formal position—is attempting to have legislation that would permit HMOs to delivery 1/3 share programs.</p>	<p>Executive proposes \$10 M to expand program—state would contribute DSH funds to help fund program</p>	<p>House generally supports same as Executive</p>	<p>Senate --same as Executive</p>
<p>Retro Medicaid Eligibility MAHP has gone on record as being against this proposal.</p>	<p>Included in Super Waiver (savings of \$28 M (gross))</p>	<p>Same as Executive</p>	<p>Same as Executive</p>
<p>Physician Rates MAHP has taken no position on the Provider tax and would generally support House Version and other recommendations to support increasing key provider rates.</p>	<p>Reductions eliminated and rates increased to Medicare under proposed Physician tax</p>	<p>Senate Rejects tax proposal and continues physician 4% rate cut</p>	<p>House rejects tax proposal and continues physician rate cut except for increase for OBs</p>

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. 071B5200018

between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 925-1710
Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084 RomanK@Molinahealthcare.com		Roman T. Kulich
		VENDOR NUMBER/MAIL CODE (004)
		BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933		
Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 7, 9, 10 - DCH		
CONTRACT PERIOD:		
	From: October 1, 2004	To: October 1, 2006
TERMS	SHIPMENT	with three 1 year renewal options
N/A		N/A
F.O.B.	SHIPPED FROM	
N/A		N/A
MINIMUM DELIVERY REQUIREMENTS		
N/A		

NATURE OF CHANGE (S):

Effective immediately, the attached subcontracting agreements with MEDTOX Labs, National Student Clearinghouse and Netwerkes.com, LTD are hereby incorporated into this contract.

AUTHORITY/REASON:

Per DMB/Acquisition Services and vendor contact (Michael Tegler) dated 4/18/05.

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

LABORATORY TESTING AGREEMENT

THIS AGREEMENT is made this ____ day of _____, 2005, between MEDTOX Laboratories, Inc. (hereafter "MEDTOX"), with address at 402 West County Road D, St. Paul, Minnesota, 55112, and Molina Healthcare of Michigan (hereafter "Customer").

WHEREAS, Customer desires to have MEDTOX provide certain laboratory services for Customer and MEDTOX is willing to provide such services under the terms and conditions set forth in this Agreement;

NOW, THEREFORE, the parties agree as follows:

1. **Services:** MEDTOX shall provide, as requested by the customer, any of the following analytical services for each specimen submitted to MEDTOX by Customer in the method prescribed by MEDTOX.
 - a. MEDTOX will run the test(s) from Exhibit A in accordance with CLIA guidelines.
2. **Reporting Test Results:** MEDTOX standard operating procedure dictates that result reports are forwarded to clients via fax. Alternative or additional reporting options may be available in some instances. MEDTOX agrees to keep all test results and attendant information confidential.
3. **Supplies:** MEDTOX will provide Customer with supplies necessary for the collection of blood specimens.
4. **Specimen Collection and Transport:** Customer shall collect the specimens and pack them for transport in a manner consistent with MEDTOX packaging instructions. The cost of sample transport will be paid by MEDTOX.
5. **Price:** MEDTOX will invoice Customer on a HCFA 1500 form at a rate of \$29.15 per sample for CPT code 83655. Taking into consideration the negotiated discount for Customer,

we will accept a net payment of \$8.00 per sample within thirty (30) days of receipt of HCFA 1500 form.

6. **Term and Renewal:**

- 6.1 This agreement shall be effective for one (1) year from the date that Customer or MEDTOX executes this Agreement, whichever occurs later, and thereafter shall continue in effect from year to year unless terminated by either party pursuant to this Agreement.
- 6.2 Either party may terminate this Agreement at any time upon ninety (90) days written notice to the other party, except as provided by paragraph five (5) regarding rate changes.
- 6.3 Any notice regarding termination or non-renewal of this Agreement shall be effective upon delivery to the other party at its regular place of business by certified mail or personal delivery. Any notice regarding termination or non-renewal will only be valid if the following parties are contacted; Dana Brown, Molina Healthcare of Michigan and Varen Herman, Clinical Sales Manager, MEDTOX Laboratories.

7. **Terms of Payment:** If necessary, MEDTOX shall submit invoices to Customer on a monthly basis for services performed under this Agreement. Customer shall pay MEDTOX the amount properly due within thirty (30) days after the receipt of invoice. Payment by Customer does not waive Customer's right to object to charges later found to be improper.
8. **Documentation:** Upon request of Customer, MEDTOX will provide Customer with documentation to establish the accuracy and reliability of the results and procedures provided by MEDTOX.
9. **Certification:** MEDTOX represents and warrants that it is in compliance, and will continue to comply during the term of this Agreement, with federal and state laws, rules, and regulations applicable to the licensing and operation of laboratory services. Upon request of Customer, MEDTOX agrees to provide documentation regarding licensing/accreditation to Customer.
10. **Indemnification:** MEDTOX warrants that MEDTOX's laboratory policies, procedures, and practices do and will at all times, comply with governmental laws, rules, and regulations. In consideration of Customer using MEDTOX as a testing laboratory, MEDTOX agrees to defend,

indemnify and hold Customer harmless from all loss, cost and expense (including court costs and attorney's fees) resulting from claims arising from the failure of MEDTOX's laboratory policies, procedures, or practices to comply with any applicable governmental laws, rules, or regulations, and from any act or failure to act in connection with MEDTOX's performance of this Agreement. Customer agrees to indemnify, defend, and hold MEDTOX and its directors, officers, agents, and employees, harmless from any loss, cost, and expense (including court costs and attorney's fees) to MEDTOX, arising out of or resulting from third parties negligence with respect to the test results after they are received by third party from MEDTOX.

11. Miscellaneous:

- A. Entire Agreement and Amendment:** This Agreement represents the entire Agreement of the parties. This Agreement may be amended or modified only in writing, signed by both parties.
- B. Assignment:** This Agreement shall not be assignable by either party without the written consent of the other.
- C. Force Majeure:** Neither party shall be liable for the failure to perform any duty or obligation that either may have under this Agreement where such failure has been occasioned by any act of God, fire, strike, inevitable accident, war, or any cause outside of the reasonable control of the party who had the duty to perform.
- D. Regulation:** Notwithstanding any other provision to the contrary, in the event that any federal, state, or local law, rule, regulation, or interpretation thereof, at any time during the term of this Agreement prohibits, restricts, or in any way materially changes the method or amount of payment for service under this Agreement, then this Agreement shall in good faith be amended by the parties to provide for reasonable payment or compensation consistent with any such prohibition, restriction, or limitation. If the parties cannot agree on such modification, this Agreement may be terminated immediately upon written notice of either party.
- E. Governing Law:** This Agreement shall be governed by and construed under the laws of the State of Minnesota.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date written below:

MEDTOX LABORATORIES, INC.

By _____

Its _____

Dated _____

MOLINA HEALTHCARE OF MICHIGAN

By _____

Its _____

Dated _____

EXHIBIT A

<u>Test Code</u>	<u>CPT Code</u>	<u>Test</u>	<u>Price</u>
64600	83655	Filter Paper Lead Screen	\$8.00
11600	85018	Filter Paper Hemoglobin	\$3.00

Netwerkes.com, Ltd.

Services Agreement

This Agreement is by and between Netwerkes.com, Ltd., ("Nw"), and MOLINA HEALTHCARE OF MICHIGAN ("Client").

For adequate consideration, the receipt of which is hereby acknowledged, the parties, intending to be legally bound, mutually agree to the following terms and conditions.

1 RECITATIONS.

Nw provides Internet-Based Transaction and Database services that afford significant economic efficiencies in the delivery of healthcare and in the administration of health plans.

1.1 Client desires to purchase and utilize certain Nw services as specified in this Agreement.

2 EFFECTIVE DATE AND TERM OF AGREEMENT.

2.1 The Effective Date of this Agreement is _____, 2005, or if no date is entered, then the date this Agreement is signed by a Nw Officer.

2.2 The Term of this Agreement shall be one (1) year, commencing on the Effective Date. Thereafter, this Agreement shall be automatically renewed for one (1) year terms, except that any party may terminate this Agreement for cause as described in Section 3.1.5 or by giving the other party 180 days written notice prior to the expiration of the initial term or any renewal term.

3 **INCORPORATION.** The following Parts (including schedules annexed thereto) are by reference incorporated into and made a part of this Agreement:

3.1 General Terms and Conditions

3.2 Internet-Based Transaction and Database Services.

4 **BINDING AGREEMENT.** This Agreement shall not become binding upon the parties until signed by a Nw Officer.

5 **REPRESENTATION AND WARRANTY.** The persons signing below warrant and represent that they are fully authorized to enter this Agreement and to bind their respective parties to its terms and conditions.

_____	Netwerkes.com, Inc.
_____	PO Box 244
_____	Appleton, WI 54912-0244
By _____	By _____
Its _____	William McLaughlin
	President and CEO
Date _____	Date _____

PART 3.1
Netwerkes.com Services Agreement

GENERAL TERMS AND CONDITIONS

- 3.1.1 INDEPENDENT PARTIES.** None of the provisions of this Agreement is intended to create, nor shall they be deemed, or construed to create, any relationship among the parties, other than that of independent entities contracting with each other solely for the purpose of this Agreement. Except as may be otherwise expressly provided in this Agreement, none of the parties hereto, nor any of their respective officers, agents, shareholders, partners, members, or employees, shall be construed to be the officer, agent, partner, shareholder, member or employee of the other.
- 3.1.2 PERFORMANCE OF SERVICES.** Netwerkes.com ("Nw") shall provide the services to Client that are set forth in the various schedules attached to this Agreement employing reasonable and workmanlike care.
- 3.1.3 FORCE MAJEURE.** No party shall be liable for any failure to perform its obligations under this Agreement where such failure results from any act of God or other cause beyond such party's reasonable control (including without limitation, any mechanical, electronic, or communications failure) which prevents such party from performing its obligations.
- 3.1.4 DISPUTE RESOLUTION.**
- 3.1.4.1** Any and all disputes, demands, claims or controversies hereto arising out of or relating to this Agreement or the breach thereof, shall be settled through Resolute Systems, Inc., Milwaukee, WI, first by attempting voluntary settlement through a non-binding mediation conference administered by Resolute Systems, within 21 days of the written request of any party, and absent a voluntary settlement through non-binding mediation, by a Resolute Systems' binding arbitration in accordance with Resolute Systems' Arbitration Rules, and judgment upon the award rendered by the arbitrator may be entered in the United States District Court for the Eastern District of Wisconsin or in the Waukesha County Circuit Court at Waukesha, WI.
- 3.1.4.2** Nothing in this dispute resolution clause shall prevent either party from resorting to judicial proceedings if interim relief from a court is necessary to prevent serious and irreparable injury to one party or to others.
- 3.1.4.3** The provisions of this section 3.1.4 shall survive the term and termination of this Agreement.
- 3.1.5 TERMINATION FOR CAUSE.** Notwithstanding any other provision to the contrary, in the event that a party materially or repeatedly defaults in the performance of any of its duties or obligations hereunder and does not substantially cure such default within thirty (30) days after being given written notice specifying the default, or with respect to those defaults which cannot reasonably be cured within thirty (30) days, if the defaulting party fails to proceed promptly after being given such notice to commence curing the default and thereafter to proceed to cure the same, then the party not in default may (without limitation of any other remedies available at law or in equity), by giving written notice to the defaulting party, terminate this Agreement as of a date specified in such notice of termination.
- 3.1.6 INSURANCE.** Both parties agree to maintain and provide evidence of the following insurance coverages that shall apply to this Agreement. The insurance coverages outlined below represent the minimum requirements.
- 3.1.6.1 Comprehensive General Liability** including products and completed operations or Managed Care Errors and Omissions Liability in the amounts of \$500,000.00 each claim or related claims, and \$1,000,000.00 aggregate.

- 3.1.6.2 **Umbrella Liability Coverage** with limit of \$1,000,000.00 may satisfy the requirements for some of the above required coverages.
- 3.1.7 **WAIVER.** No failure, or delay, of any party in exercising any right, or power, given to it under this Agreement shall constitute a waiver. No waiver of any breach of any provision of this Agreement shall constitute a waiver of any prior, concurrent, or subsequent breach. No waiver of any breach or modification of this Agreement shall be effective unless contained in a writing executed by both parties.
- 3.1.8 **NON-EXCLUSIVITY.** This Agreement is non-exclusive, and does not limit, or impair the right of any party to contract with other persons, or entities, including, but not limited to, other providers, preferred provider organizations, third party administrators, health maintenance organizations, or other participating provider arrangements.
- 3.1.9 **INTEREST IN NAMES, MARKS AND COPYRIGHTS.** Nothing in this Agreement shall be construed to grant either party any right, title or interest in any good will, mark, copyright or other form of intellectual property of the other party (including those of its parent and subsidiary companies). A party's names, marks, and other intellectual property (including those of its parent and subsidiary companies) may not be used without express, prior written consent of the other party, as appropriate.
- 3.1.10 **LIABILITY AND INDEMNITY.**
- 3.1.10.1 **Limitation of Liability.** In no event shall Nw be liable for any indirect, exemplary, punitive, or consequential damages including without limitation lost profits, loss of data, and loss of business, even if Nw has been advised of the possibility of such damages.
- 3.1.10.2 **Duty of Client.** Client shall have the affirmative duty to use businesslike care to verify the accuracy of Nw's performance under this Agreement. Nw shall not be liable to the extent that any damages arising from any cause or claim about which Client should have known and have taken timely corrective action had Client exercised such care.
- 3.1.10.3 **Duty of Nw.** Nw shall have the affirmative duty to use businesslike care to verify the accuracy of Client's performance under this Agreement. Client shall not be liable to the extent that any damages arising from any cause or claim about which Nw should have known and have taken timely corrective action had Nw exercised such care.
- 3.1.10.4 **Disclaimer of Warranty.** **EXCEPT AS PROVIDED EXPRESSLY IN THIS AGREEMENT, Nw DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.**
- 3.1.10.5 **Indemnification**
- 3.1.10.5.1 Client agrees to indemnify and hold Nw harmless, at its own expense, from and against all losses, claims, costs, damages and liabilities arising out of injuries (including death) or damage to property to the extent resulting from or pertaining to Client's breach of this Agreement, its negligence or willful misconduct or that of its agents, employees, subcontractors or distributors.
- 3.1.10.5.2 Nw agrees to indemnify and hold Client harmless, at its own expense, from and against all losses, claims, costs, damages and liabilities arising out of injuries (including death) or damage to property to the extent resulting from or pertaining to Nw's breach of this Agreement, its negligence or willful misconduct or that of its agents, employees, subcontractors or distributors.

- 3.1.10.5.3 The indemnification obligations of the parties under this section shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, cost, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.
- 3.1.11 **BINDING EFFECT.** This Agreement shall be binding upon, and inure to, the benefit of the parties, their permitted successors and assigns, and any successors by merger, consolidation, or other reorganizations, without limitation.
- 3.1.12 **NOTICES.** Any notice, consent, approval, request, or other communication required, or permitted to be given pursuant to this Agreement, shall be in writing, and shall be either delivered personally or by facsimile, or sent by first class mail, postage prepaid, to the address appearing above the party's signature lines to this Agreement, or to such other address as a party may notify the other party, from time to time. If notice is sent by mail, it shall be deemed effective 72 hours after deposit in the United States mail.
- 3.1.13 **CONSTRUCTION.** The language in all parts of this Agreement shall in all cases be construed simply according to its fair meaning and not strictly for or against either party.
- 3.1.14 **GOVERNING LAW.** This Agreement is executed, and has been delivered, in the State of Wisconsin and shall be governed by the laws of the State of Wisconsin as to both interpretation and enforcement, without regard to the conflicts of law principles of that State. The parties consent to the jurisdiction of the United States District Court for the Eastern District of Wisconsin or of the Waukesha County Circuit Court in Waukesha, Wisconsin, with respect to any proceeding arising out of this Agreement.
- 3.1.15 **HEADINGS.** All paragraphs and other headings in this Agreement are for reference purposes only, and are not intended to describe, interpret, define, or limit the scope, extent, or intent of this Agreement, or any provision hereof.
- 3.1.16 **SEVERABILITY.** If any provision of this Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall in no way be affected or impaired thereby.
- 3.1.17 **ENTIRE AGREEMENT.** Each party acknowledges that it has read this Agreement, understands it, and agrees to be bound by its terms and further agrees that it is the complete and exclusive statement of the Agreement between the parties, which supersedes and merges all prior proposals, understandings and all other agreements, oral and written between the parties relating to the subject matter of this Agreement. This Agreement may not be modified or altered except by written instrument duly executed by both parties.
- 3.1.18 **PAYMENT OF IMPLEMENTATION AND SERVICE FEES.**
- 3.1.18.1 **Fees Due.** Client shall pay the implementation and service fees as provided in the various Schedules attached to this Agreement. Except as may be expressly provided otherwise in those Schedules, Nw shall invoice Client on a monthly basis. All invoices are due and payable within 30 days from Nw's invoice date.
- 3.1.18.2 **Service Charge.** Client agrees to pay a service charge of one and one-half percent (1.5%) per month, or the highest legally permitted rate, whichever is less, on any balance not paid within 30 days from Nw's invoice date. In the event of any default of the payment provision herein, Client agrees to pay, in addition to any defaulted amount, all Nw's actual legal costs, including but not limited to, attorney fees, collection costs and court costs Nw has incurred to collect overdue amounts.

- 3.1.18.3 **Payment Default.** A balance that is outstanding more than ninety (90) days after Nw's invoice date shall be in default, in which event (i) Client agrees to pay, in addition to any defaulted amount, all Nw's actual legal costs, including but not limited to, attorney fees, collection costs and court costs Nw has incurred to collect overdue amounts, and (ii) Nw may suspend provision of services under this Agreement until the outstanding balance and service charges are paid in full.
- 3.1.19 **TAXES.** Client will pay to Nw, amounts equal to any taxes, however designated or levied, based upon compensation paid to Nw or upon this Agreement or the services provided hereunder, or their use, including state and local sales, use privilege or excise taxes, and any taxes paid or payable by Nw in respect of the foregoing, but excluding any taxes based on the income of Nw.
- 3.1.20 **CONFIDENTIALITY AND NON-DISCLOSURE.** The Parties acknowledge that in the course of fulfilling their mutual obligations under this Agreement a party may request of or be provided by the other party certain confidential and proprietary information, including trade secrets, which is of substantial value to the providing party. This information may be in both oral and written form. Each party acknowledges that the disclosure of any such material to third parties will prejudice the other's ability to conduct its business successfully. Therefore, each party agrees:
- 3.1.20.1 It will preserve as confidential all Confidential Information which it may obtain or prepare. Without the providing party's prior written consent, which may be given or withheld by the providing party in its sole and absolute discretion, the receiving party will not (a) disclose any Confidential Information to any third party nor give any third party access thereto; (b) use any Confidential Information except in the performance of its obligations under this Agreement; (c) disclose to any third party the terms of this Agreement or the fact that Confidential Information is being made available; provided, however, that the foregoing will not apply to the extent it is, in the opinion of counsel, required to disclose any Confidential Information by applicable law or legal process as long as it promptly notifies the providing party of such pending disclosure and consults with the providing party prior to such disclosure as to the advisability of seeking a protective order or other means of preserving the confidentiality of the Confidential Information. If it is so required to disclose any Confidential Information it will use reasonable efforts to obtain assurances that the information so disclosed will continue to be accorded confidential treatment. In the event that disclosure is required by law (in the opinion of counsel), the parties will consult in advance and cooperate with respect to any required press release or other disclosure.
- 3.1.20.2 A receiving party will use at least the same degree of care to avoid the publication, disclosure, reproduction or other dissemination of the Confidential Information as it employs with respect to its own valuable, proprietary information which it protects from unauthorized publication, disclosure, reproduction or other dissemination. The receiving party will limit access to the Confidential Information to those of its personnel, advisors and independent contractors having an essential need-to-know. If the receiving party discloses Confidential Information to an advisor or independent contractor, it will take reasonable steps to assure that the advisor or independent contractor understands the Confidential Information may be used only for the purpose of performing its services for the receiving party and may not be disclosed to others.
- 3.1.20.3 All documents, drawings, records, data bases, programs and other physical media of expression incorporating or containing any Confidential Information furnished to a receiving party are acknowledged to be the property of the providing party and the receiving party will promptly surrender it upon the expiration or termination of this Agreement. In addition, except to the extent the receiving party is advised by counsel that such action is prohibited by law, the receiving party will also destroy all copies, summaries and notes thereof made by it and all analyses, compilations, studies, reports or other documents or materials which are prepared by

it or its advisors and which contain or reflect any Confidential Information received by it. After such expiration or termination the receiving party will make no further use of any of these materials for any purpose whatever. The foregoing will apply regardless of the reasons for or circumstances surrounding such expiration or termination.

- 3.1.20.4 For the purposes of this Agreement, the term "Confidential Information" means: (i) information relating to a providing party concerning its business, assets, liabilities, operations, affairs, financial condition and projections; client lists, information concerning clients' needs, preferences, marketing plans, and pricing or fee schedules; information about service techniques, service ethic, job set-up procedures, project management procedures, vendor selection and management techniques, products and sales; software code and product and services specifications, design and performance standards, plans for future product development and enhancements; and results and information obtained or assembled for the providing party's clients, contracts, customers, products, plans or prospects which has not been made available to the public; and (ii) all analyses, compilations, studies, reports, records or other documents or materials which contain, or are prepared on the basis of, any such non-public information and which are either furnished to the receiving party or are prepared by or for it or any of its directors, owners, officers, employees, agents or advisors. Notwithstanding the above, "Confidential Information" does not include any information that (i) is or becomes public knowledge otherwise than by the receiving party's act or omission; or (ii) is or becomes available to the receiving party without obligation of confidence from a source (other than the providing party) having the legal right to disclose that information; or (iii) is already in the receiving party's possession in documented form without an obligation of confidence and was not received by it in anticipation of the transaction under discussion or as a result of a prior relationship with the providing party.
- 3.1.20.5 Money damages will not be a sufficient remedy for any breach of this section 3.1.20 by a party and that in addition to all other remedies which may be available, the other party will be entitled pursuant to section 3.1.4.2 of this Agreement to specific performance and injunctive or other equitable relief, without bond, as a remedy for any such breach or threatened breach.
- 3.1.20.6 **Abstract Statistical Compilations.** Client hereby agrees and acknowledges that Nw may use abstract statistical data derived from transactions through Nw in the formulation of statistical summaries or samplings; provided, however, any such summary or sampling shall not disclose directly or indirectly (a) information the disclosure of which is prohibited by law, or (b) the identities of Client, or its employees, providers, or patients.
- 3.1.20.7 **Client's Wholly-Owned Subsidiaries.** This section does not prohibit disclosure of Confidential Information by Client to a wholly-owned subsidiary. Client agrees that the subsidiary will otherwise be bound to the provisions of this section.
- 3.1.20.8 Client shall not be considered a "receiving party" under this section with respect to (i) data submitted to Nw's website under this Agreement by Client, its customers, and providers, and (ii) analyses, compilations, studies, and reports derived from such data.
- 3.1.20.9 To the fullest extent permitted by law, all of the covenants and agreements contained in this section 3.1.20 will survive the term and termination of this Agreement.

Rev. 5/2001

PART 3.2
Networks.com Services Agreement

INTERNET-BASED TRANSACTION AND DATABASE SERVICES

- 3.2.1 PURPOSE.** It is the parties' purpose and desire to facilitate certain healthcare transactions by electronically receiving data relating to or effectuating them using the Internet as the medium of communication in substitution for conventional paper-based documents and to assure that such transactions are not legally invalid or unenforceable as a result of the use of available electronic technologies for the mutual benefit of the parties.
- 3.2.2 SERVICES.** Nw shall provide the services to Client that are set forth in Schedule 3.2.A employing reasonable and workmanlike care, subject to System Availability and Technical Support as set forth in Schedule 3.2.B.
- 3.2.3 COMPENSATION.** Client shall pay the fees prescribed Schedule 3.2.C in accord with its terms and with section 3.1.18.
- 3.2.4 SYSTEM OPERATIONS.** Each party, at its own expense, shall acquire and maintain hardware, software, services, and testing necessary to transmit and receive Internet communications effectively and reliably in support of the services provided by Nw to Client under this Agreement, including that equipment, software, and services specified in Schedule 3.2.C of this Agreement.
- 3.2.5 SECURITY OF TRANSACTIONS AND DATA.**
- 3.2.5.1** Each party shall properly use security procedures that are reasonably sufficient to ensure that all transmissions of data between Client and Nw are authorized and to protect its business records and data from improper access.
- 3.2.5.2** It is the parties' intention that commercially reasonable standards of security in the circumstances be utilized for Internet transmission of data among them. To this end, Nw may, from time-to-time, recommend that Client implement improved security practices, procedures and services for Internet transmission of data. If Client does not implement such recommendation, Client shall indemnify and hold Nw harmless, at its own expense, from and against all losses, claims, costs, damages and liabilities arising out of injuries (including death) or damage to property to the extent resulting from or pertaining to Client's failure to implement the recommendation.
- 3.2.6 OWNERSHIP OF SOFTWARE.** Nothing in this Agreement shall be construed to convey to Client any right, title or interest in the software applications or source code used or developed by Nw to perform services under this Agreement.
- 3.2.7 LIMITATION TO TRANSACTION AND DATABASE SERVICES.** Client specifically acknowledges that in performing services under this Part 3.2 of the Agreement, Nw does not practice medicine, and that Client is solely responsible for all clinical decisions regarding the provision of its medical services to third parties.

SCHEDULE 3.2.A
Internet-Based Transaction and Database Services

I. IMPLEMENTATION

None.

II. Nw SERVICES

- A. Receipt of HCFA-1500, UB-92, and ADA Dental claims through Nw's website from providers.
- B. Private-labeling of netwerkes.com website with Client's logo and color scheme positioned on all web pages with the modifier "Powered by Netwerkes.com" including the Netwerkes.com logo.
- C. Pre-Authorization DDE ("Direct Data Entry") which will permit Client providers to enter pre-authorizations and Client staff to view/print pre-authorization information. The DDE screens and reports to be used by Molina providers and staff are subject to agreement by Client and Nw.

Nw's will develop the Pre-authorization product within 30 days of the signature date of this contract per the specifications in the following:

- ATTACHMENT 1 – Criteria Defining Successful Development Of Pre-authorization Product
- ATTACHMENT 2 - MOLINA Pre-authorization Form
- ATTACHMENT 3 - Data Tables Needed From MOLINA.

SCHEDULE 3.2.B
Internet-Based Transaction and Database Services

1. **System Availability.** Nw Internet-based applications will normally be available 24 hours a day except for—
- A. Causes beyond Nw's control (including, without limitation, any mechanical, electronic or communications failure);
 - B. Failure of service providers to Client that are independent of Nw, including the transmission quality of Client's local telephone lines, the speed of Internet connections, and the operation or reliability of any Internet server or computer not owned or operated by Nw; and
 - C. Downtime for maintenance and upgrading of systems components, application modifications and enhancements which will be scheduled for Saturdays, Sundays and legal holidays between the hours of 8:00 AM and 5:00 PM Central time. Nw will normally give system users 24 hours' advance notice of such downtime.

II. Technical Support

- A. Telephone and/or E-Mail-based technical support will be available Monday through Friday from 8:00 AM to 5:00 PM Central time, except for Saturdays, Sundays and legal holidays, for questions relating to the operation and use of the services or products provided by Nw to Client under this Agreement.
- B. Client's Technical support for Services set forth in Schedule 3.2.A shall be directed through a single person or that person's designee:

Client's primary Technical Support person is _____.

The secondary Technical Support person is _____.
- C. Client shall be responsible for technical support relating to the installation and maintenance of its computer hardware and local area network (if any), and for installation, operation, and maintenance of its software applications (including operating systems such as Windows, OS/2, MacOS or UNIX).
- D. Client shall be responsible for its Internet connections and support for Internet services not related to the performance of Nw web site. Support for Client's connectivity to the Internet must be directed to Client's Internet Service Client (ISP).

SCHEDULE 3.2.C
Internet-Based Transaction and Database Services

Compensation For Services

I. Fees for Services.

A. Implementation Fee (includes private -labeling)

None.

B. Service Fee

1. Claims received electronically: \$0.35 per claim*.

2. Direct Data Entry Pre-Authorizations, per transaction*:

Volume	Unit Price
0 to 10,000	\$0.75
10,001 to 25,000	\$0.68
25,001 to 50,000	\$0.60
50,001 to 75,000	\$0.53
75,001 to 100,000	\$0.45
> 100,000	\$0.38

3. Direct Data Entry Referrals, per transaction*:

Volume	Unit Price
0 to 10,000	\$0.50
10,001 to 25,000	\$0.45
25,001 to 50,000	\$0.40
50,001 to 75,000	\$0.35
75,001 to 100,000	\$0.30
> 100,000	\$0.25

* "Per transaction" is defined as a Pre-authorization Request transmitted by a provider and received and actionable by MOLINA UM staff.

C. Minimum Charge

1. For months 1, 2, and 3 following the effective date of this Agreement:

Minimum monthly charge: \$3000.00

2. Starting with month 4 following the effective date of this Agreement:

Minimum monthly charge: \$5000.00

* This fee is waived as long as the Michigan Department of Community Health ("MDCH") subsidizes the transmission of claims to Client.

D. Billing Address:

II. Payment Terms.

- A. Service Fees shall be invoiced on the first day of the month for the immediately preceding month and shall be paid as provided under section 3.1.18 of this Agreement.

ATTACHMENT 1

MOLINA CRITERIA DEFINING SUCCESSFUL DEVELOPMENT OF PRE-AUTHORIZATION PRODUCT

Molina hereby expressly acknowledges and agrees that if the 11 criteria below are demonstrated within thirty days of contract signing, Molina shall agree that *Netwerkes.com* (hereinafter "Nw") shall have successfully demonstrated its Pre-authorization development and product for general implementation by MOLINA per the terms of this contract and Molina hereby agrees to be bound by said terms and conditions. MOLINA agrees to provide the data needed for development and operation of this Pre-authorization product as described in Attachment 3 within five business days of the signing date of this contract.

1. Development of an html page/screen formatted analogously to MOLINA's current paper pre-authorization form, including specifications detailed in Attachment 2.
2. Nw customers who transmit claims to MOLINA will have a "Referral/Pre-authorization" tab on their main page after login, and will then find a "MOLINA" selection which will link to the MOLINA Pre-authorization form. Nw will provide MOLINA the capacity to place a hyperlink on the MOLINA.com website to link to Nw's website non-Nw's customers to then login to the MOLINA-branded Pre-authorization screen.
3. The Pre-authorization screen will have drop-down fields for procedure and diagnosis codes that are current through the current 2005 updates.
4. The Pre-authorization form fields for selecting participating providers and facilitates will have a "smart-search" feature.
5. MOLINA staff can be designated to have the capacity to create additional MOLINA staff users and be able to create providers/provider-users to access the Pre-authorization system.
6. MOLINA user views will provide for sorting of pre-authorizations by MOLINA user, and then will provide for the sorting of pre-authorizations by status type and/or date the pre-authorization was created by the providers.
7. Pre-authorization forms will be able to be printed to an Adobe.pdf document.
8. When a MOLINA UM staff user Accepts, Pends, or Denies a pre-authorization request the system will automatically generate and send an email notice to the requesting provider (whose email address will be provide in the Provider Table provided by MOLINA).
9. The MOLINA referral system will be available "24/7" consistent with Nw's general system availability.
10. Nw will provide support and training to MOLINA staff and providers involved with the pre-authorization product. Nw will provide it's standard diligent customer support and response to resolve issues within 48 hours where possible or provide a time-frame for resolution where the issue requires more time or resources.
11. Pre-authorizations will be able to be submitted from two provider sites selected by MOLINA, be viewed/responded to by MOLINA UM staff, and results be able to be received/viewed by the submitting providers.

**ATTACHMENT 2
PRE-AUTHORIZATION FORM FIELDS**

FORM FIELD	FIELD TYPE	DATA SOURCE	ISSUE / QUESTION
Request #	Numeric	Auto-generated by NW	
Authorization / Referral #	Numeric	Manually entered by MOLINA	
Date of Request	Date: mm/dd/yyyy	Auto-generated by NW	
Care Type	Drop list (SEE BELOW)	Manually entered by MOLINA	
MEMBER INFORMATION			
Member Name (Last)	Alpha	Smart-search, auto-filled by NW from Member Table, and cross-walks / auto-fills the Member ID, Address, & Telephone Number.	
Member Name (First, MI)	Alpha	Auto-filled (see above).	
Member I.D.	Numeric	Either: 1) auto-filled by NW from Member Table, or 2) key entered and which then selects the Member Name.	
(Member) Address (# and Street)	Text	Auto-filled from Member file. Editable, allowing for local over-ride / correction.	Alert on the form to alert for user to check auto-filled address/telephone against local confirmation.
(Member) Address (City)	Text	Auto-filled from Member file. Editable, allowing for local over-ride / correction.	
(Member) Address (State)	Text	Auto-filled from Member file. Editable, allowing for local over-ride / correction.	
(Member) Address (Zip)	Text	Auto-filled from Member file. Editable, allowing for local over-ride / correction.	
(Member) Phone Number	Numeric: (nnn) nnn-nnnn	Auto-filled from Member file. Editable, allowing for local over-ride / correction.	
REFERRAL / SERVICE TYPE REQUESTED			
Referral / Service Type Requested	Drop list (SEE BELOW)	Manually entered by MOLINA	
Date of (requested) Service, Start	Date: mm/dd/yyyy	Manually entered by MOLINA	
Date of (requested) Service, End	Date: mm/dd/yyyy	Manually entered by MOLINA	
Number of Visits (requested)	Numeric	Manually entered by MOLINA	

**ATTACHMENT 2
PRE-AUTHORIZATION FORM FIELDS**

REQUESTING PROVIDER INFORMATION			
Requesting Provider Name (Last, First)	Alpha	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up).	
Specialty	Alpha	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up).	
Phone Number	Numeric: (nnn) nnn-nnnn	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up).	
Point of Contact (Name & Title)	Alpha	Auto-filled from login identity. Editable, allowing for local over-ride.	
Phone Number (of Point of Contact)	Alpha	Auto-filled from login identity. Editable, allowing for local over-ride.	
Address (#, Street)	Text	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	
Address (City)	Text	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	
Address (State)	Text	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	
Address (Zip)	Text	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	
Fax Number	Numeric: (nnn) nnn-nnnn	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	
Provider email address	text	Auto-filled from Provider - Nw account information (entered by MOLINA staff upon set-up). Editable, allowing for local over-ride.	Option to automatically send an email notice to the requesting provider when the pre-auth request is Accepted, Pending, or Denied.
Attachments	"browse-and-click-to-attach" files (documents, images, etc.)	Attachments made by provider.	

**ATTACHMENT 2
PRE-AUTHORIZATION FORM FIELDS**

PROVIDER REFERRED-TO INFORMATION	NOTE: there will be two sets of fields: 1) In-network Providers / Facilities, whose information will auto-fill from the Provider Table by drop-lists, or 2) OON fields for manual entry.	
Referred-To Provider Name (Physician, Facility)	(see above)	Auto-filled from Provider Table, OR manually entered in OON Provider / Facility Fields.
Specialty	(see above)	Auto-filled from Provider Table or manually entered.
Address (#, Street, City, State, Zip)	(see above)	Auto-filled from Provider Table or manually entered.
Phone Number	Numeric: (nnn) nnn-nnnn	Auto-filled from Provider Table or manually entered.
Fax Number	Numeric: (nnn) nnn-nnnn	Auto-filled from Provider Table or manually entered.
SERVICE REQUEST INFORMATION		
ICD-9 CODE	Drop list	Provider selects.
Description (ICD-9)	Drop list	Provider selects.
CPT / HCPC Code #	Drop list	Provider selects.
Description (CPT / HCPC Code #)	Drop list	Provider selects.
Clinical Information	Text.	Provider selects.
MOLINA USE ONLY		MOLINA to declare size of field.
Authorization Status	Drop list (SEE BELOW)	
Approved LOS (Length of Service)	Numeric	Molina UM selects.
Comments	Text	Molina UM inputs.
UM Representative	Text	Molina UM inputs.
Date	Date: mm/dd/yyyy	Auto-filled from login identification.
		Auto-filled by date/time of entry.

**ATTACHMENT 2
PRE-AUTHORIZATION FORM FIELDS**

DROP LISTS Care Type	LIST CONTENT	NOTES
	Routine	
	Urgent / Emergent	
	Inpatient Admission	
	Surgical Procedure	
	Diagnostic Procedure / Radiology	
	Home Health	
	Hospice	
	DME	
	Specialist Consult / Follow-up	
	PT, OT, SP	
	O2 Respiratory Supplies	
	Other	Field provided for provider to enter content description of "Other".
Pre-authorization Status	Requested	The initial status of a pre-auth upon submission from a provider and before touched by MOLINA UM.
	Approved	Color differentiation for each status type.
	Pending	Color differentiation for each status type.
	Denied	Color differentiation for each status type.
		Status assigned by MOLINA UM when further consideration required for decision to Approve / Deny.
		Color differentiation for each status type.

DATA TABLES NEEDED FROM MOLINA

TABLES NEEDED FROM MOLINA	FIELDS	NOTES
Recipient by PCP Assignment	(Column in the Provider Table with the MEDICAID Recipient ID)	
Provider Table (PCP, SCP, Facilities)	Provider Name (Last, First) Specialty Phone Number Address (#, Street) Address (City) Address (State) Address (Zip) Fax Number Provider email address	This field differentiates PCP, SCP, and Facility.
Member Table	Member Name (Last) Member Name (First, MI) Member ID (Member) Address (# and Street) (Member) Address (City) (Member) Address (State) (Member) Address (Zip) (Member) Phone Number MEDICAID Recipient ID MOLINA Recipient ID	
MOLINA UM Staff Assignment Table	MOLINA UM users Provider Area Code of Assignment	Referrals assigned by PCP Area Code



National Student Clearinghouse DegreeVerify Agreement for Requestors

1. **Parties.** The National Student Clearinghouse ("Clearinghouse"), a not-for-profit corporation organized under the laws of Virginia, provides a nationwide, central repository for information about the enrollment and educational achievements of postsecondary education students. Educational institutions regularly report student enrollment and degree information to the Clearinghouse. Acting as agent for educational institutions, the Clearinghouse reports student enrollment and degree information to authorized recipients. Employers, employment agencies, background checking firms, and others that require confirmation of degree status, as well as entities that act on behalf of these organizations, are eligible to request verification of specified degree and enrollment information through the Clearinghouse ("Requestors"). The Clearinghouse and the undersigned Requestor agree to the terms and conditions set forth in this DegreeVerify Agreement ("Agreement").

2. **Consideration.** Acting as agent for educational institutions, the Clearinghouse agrees to verify an individual's degree and other educational achievements, including dates of attendance, in a post-secondary educational institution in accordance with this Agreement. The Requestor agrees to pay the appropriate transaction fee and otherwise abide by the terms of this Agreement.

3. **Services.** (a) In order to verify a subject's dates of attendance, degrees, and other educational achievements, the Requestor must certify that the student has provided the Requestor with a signed and dated written consent for the educational institution or the Clearinghouse to release degree and/or enrollment information to the Requestor or the company it represents.

(b) The Requestor agrees that so long as this Agreement remains in effect it will maintain each student's written consent to release the requested information in a medium that may be retrieved in a perceivable form for two years from the date of the consent and will provide a copy to the Clearinghouse upon request. The Requestor agrees further that it will provide the Clearinghouse with a copy of every remaining consent to release information upon termination of this Agreement if requested by the Clearinghouse.

(c) The Clearinghouse agrees to provide a timely response to each verification request based exclusively on data provided by participating educational institutions. The Clearinghouse does not release or confirm social security numbers and will not release any information, and will consult with or refer a request to the educational institution, if the information may not be released under FERPA, if requested by the educational institution, or if the Clearinghouse is unable to identify the requested record. The Requestor using the Clearinghouse's automated, web based verification service agrees to contact Customer Service at 703-742-4200 for additional information if advised that the system is unable to verify information for any reason.

4. Privacy and Security of Information. The Clearinghouse agrees to institute and maintain reasonable controls to ensure the integrity and security of its database and data transmission systems, including the security of credit card numbers and all other data submitted by the Requestor. The Requestor acknowledges and agrees that the Clearinghouse maintains a detailed record of each verification request that is attempted or completed ("request record") and makes the request record available to the pertinent educational institution or its designated agent for review.

5. Re-disclosure of information prohibited. A Requestor may obtain information from the Clearinghouse under this Agreement on behalf of an employer, employment agency, background checking firms, and similar organizations, and may release the information to that other entity. The Requestor agrees that it will not otherwise release, transfer, distribute, share or re-disclose any information that it has obtained from the Clearinghouse to any other entity or individual, whether for sale or free of charge, except to the student whose information was verified. The Requestor agrees further that if it obtains information from the Clearinghouse under this Agreement on behalf of another entity, it will release the information to that other entity only on the condition that the other entity will not release, transfer, distribute, share or otherwise re-disclose any of the information obtained from the Clearinghouse to any other entity or individual, whether for sale or free of charge, except to the student whose information was verified.

6. Insurance, Warranties and Disclaimers of Liability. The Clearinghouse warrants that under this Agreement it verifies or releases only information provided by educational institutions. The Clearinghouse agrees to maintain insurance covering errors and omissions in its data processing operations in the amount of at least two million dollars (\$2,000,000).

The Clearinghouse does not warrant or guarantee the completeness, accuracy or reliability of information in its database and disclaims any express or implied warranties of merchantability or fitness for a particular purpose. The Clearinghouse specifically disclaims any responsibility or liability for errors or omissions in information provided by educational institutions, including direct, indirect, incidental, special, or consequential damages resulting from the use of information provided by the educational institution and verified or released by the Clearinghouse under this Agreement.

Both parties agree to comply with all applicable laws and regulations governing the activities and services provided under this Agreement, including in particular FERPA and other laws concerning the privacy and confidentiality of information and records.

7. Notices. The Requestor agrees to provide all notices under this Agreement to:

National Student Clearinghouse
13454 Sunrise Valley Drive, Suite 300
Herndon, VA 20171
Attn: President
Fax: 703-742-4239

The Clearinghouse agrees to provide all notices to the Requestor to the signatory and address below unless otherwise instructed in writing by the Requestor. The Clearinghouse considers the signatory to this Agreement as its primary contact for all operational, systems, and billing issues related to enrollment verification unless otherwise instructed in writing by the Requestor.

8. Effective Date, Termination, and Modification. The effective date of this Agreement is the date by which it is signed by both parties. This Agreement remains in effect until terminated by either party by providing sixty (60) days written notice. The Clearinghouse and the Requestor agree that any subsequent modifications to this Agreement will be made only in writing.

9. **Choice of Law.** The Clearinghouse and the Requestor agree that all rights and obligations under this Agreement will be interpreted, governed and enforced under the laws of Virginia, without giving effect to its choice or conflicts of law provisions.

10. **Survival.** The Clearinghouse and the Requestor agree that all representations, covenants, prohibitions, warranties, and disclaimers of liabilities between the parties will survive the termination of this Agreement for any reason and in any manner and will remain in full force and effect between the parties.

11. **Fees.** The Requestor agrees to pay a transaction fee in accordance with the Clearinghouse's published schedule of fees for each verification request for which the Clearinghouse provides the requested information directly or upon consultation with the educational institution. The Clearinghouse's schedule of fees is available at its web site at www.studentclearinghouse.org. The Clearinghouse requires a minimum usage of \$25 per quarter in order to qualify for membership status.

INITIAL ONE OF THE OPTIONS BELOW

- a. The Requestor agrees that it will not submit degree verification requests directly to any educational institution whose records may be obtained from the Clearinghouse, and will pay the discounted rate for verifications. _____ **(initial)**
- or -
- b. The Requestor does not agree that it will submit all degree verification requests for participating educational institutions directly to the Clearinghouse, and will pay the higher standard rate for verifications. _____ **(initial)**

The Requestor agrees to remit payment within thirty (30) days of receipt of the Clearinghouse's statement for services rendered.

NATIONAL STUDENT CLEARINGHOUSE
Authorized Representative

Molina Healthcare of MI _____
Requesting Organization

Signature _____

Signature _____

Name _____

Authorized Representative

Name: Roman T. Kuhch

Title _____

Title: President and CEO

Date _____

Date _____

www.studentclearinghouse.org

Address: 100 West Big Beaver, Suite 600

City/State/Zip Troy, MI, 48084

D-U-N-S® Number: # _____

E-mail Address: _____

Telephone _____

Please return all pages of this agreement to the Clearinghouse.

**SCHEDULE I
REQUIRED PROVISIONS**

1. **Right to Audit.** MHI shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. MHI shall permit such inspection at MHI's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of MHI related directly or indirectly to the goods and services furnished under the terms of this Agreement. MHI shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(i)).
2. **Confidentiality.** MHI shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
3. **Hold Harmless.** MHI agrees that under no circumstance shall a subscriber or enrollee in Medicare Advantage be liable to MHI for any sums owed by MHI to MHI. (42 CFR 422.504(g)(1)(i)).
4. **Delegation.** If MHI is delegated any of the activities or functions of MHI as required in its contract with CMS, MHI agrees to comply with all applicable contractual provisions in the same manner as if MHI had executed such contract with CMS directly. The activities or functions delegated to MHI are set forth in the Amendment. In the event CMS or MHI determines, in its sole discretion, that MHI has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. The performance of such delegated activities shall be monitored by MHI on an ongoing basis, and MHI shall cooperate with all reasonable requests made by MHI in order to accomplish such monitoring. If MHI is delegated credentialing activities, MHI's credentialing process will be reviewed and approved by MHI, and such credentialing process will be audited by MHI on an ongoing basis; further, MHI agrees that its credentialing process will comply with all applicable NCQA standards. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).
5. **Reporting.** MHI shall comply with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 422.257. (42 CFR 422.504(a)(8)).
6. **Accountability.** MHI acknowledges and agrees that MHI is accountable to CMS for overseeing any functions or responsibilities delegated to MHI. (42 CFR 422.504(i)(3)(i)(A)).
7. **Medicare Compliance.** MHI shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

2005-1 AMENDMENT TO SERVICES AGREEMENT

This 2005-1 Amendment to Services Agreement (this "Amendment") is made by and between Molina Healthcare of Michigan, Inc. ("MHM") and Molina Healthcare, Inc. ("MHI").

MHM and MHI agree as follows:

1. MA-SNP Program. MHM and MHI have previously executed that certain Services Agreement whereby MHI provides consultation and assistance services as may be requested from time to time by MHM. MHM has applied to CMS as a Medicare Advantage Plan. MHM and MHI acknowledge and agree that the Services Agreement shall be modified and amended in order to include such consultation and assistance services as may be requested by MHM from time to time related to the Medicare program. MHI shall be compensated for services provided to MHM as set forth in the Services Agreement.
2. Medicare Required Provisions. Schedule 1 sets forth certain provisions required by federal statutes and regulations applicable to the Medicare program, and are incorporated into the Services Agreement. In the event any of the required provisions conflict with any provision in the Services Agreement, as amended from time to time, the required provisions shall control.
3. Full Force and Effect. Except as amended herein, the Services Agreement remains unmodified and in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date set below their signatures.

Molina Healthcare of Michigan, Inc.

Molina Healthcare, Inc.

[SIGN NAME] _____

[SIGN NAME] _____

[PRINT NAME]

[PRINT NAME]

[DATE] _____

[DATE] _____

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

February 10, 2005

**CHANGE NOTICE NO. 3
 TO**

CONTRACT NO. 071B5200018

**between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084	TELEPHONE (248) 925-1710 Roman T. Kulich
	VENDOR NUMBER/MAIL CODE (004)
	BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 7, 9, 10 - DCH	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT with three 1 year renewal options <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective 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 17110000251
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/EPSTD 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/EPSTD target population. The Contractor will obtain information from the contracted agencies regarding members who require Well Child/EPSTD services or are overdue for Well Child/EPSTD services. The Contractor will monitor services provided to these identified members to ensure that the members receive the required services.

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. 071B5200018

**between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084	TELEPHONE (248) 925-1710 Roman T. Kulich
	VENDOR NUMBER/MAIL CODE (004)
	BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 7, 9, 10 - DCH	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT with three 1 year renewal options <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

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 17110000251
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.**

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

CONTRACT NO. 071B5200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR <p style="text-align: center;">Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084</p>	TELEPHONE (248) 925-1710 Roman T. Kulich VENDOR NUMBER/MAIL CODE (004) BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 <p style="text-align: center;">Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 7, 9, 10 - DCH</p>	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">with three 1 year renewal options</p> <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	
MISCELLANEOUS INFORMATION: <p>NATURE OF CHANGE (S):</p> <p style="text-align: center;">Please note effective 10/1/04 the attached changes are hereby incorporated into this contract.</p> <p>AUTHORITY/REASON:</p> <p style="text-align: center;">Per DMB/Acquisition Services and agency contact (Cheryl Bupp) dated 10/1/04.</p>	
<p>Total Estimated Contract Value Remains: \$157,894,736.00</p>	

**Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 17114001168
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.**

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. 071B5200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084	TELEPHONE (248) 925-1710 Roman T. Kulich VENDOR NUMBER/MAIL CODE (004) BUYER/CA (517) 241-1647 Irene Pena, CPPB
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries – Regions 1, 4, 6, 7, 9, 10 - DCH	
CONTRACT PERIOD: From: October 1, 2004 To: October 1, 2006	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT with three 1 year renewal options <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	
MISCELLANEOUS INFORMATION: <p>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.</p> <p>Estimated Contract Value: \$157,894,736.00</p>	

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 will 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.

<p>FOR THE VENDOR:</p> <p style="text-align: center;">Molina Healthcare of Michigan Inc.</p> <hr/> <p style="text-align: center;">Firm Name</p> <hr/> <p style="text-align: center;">Authorized Agent Signature</p> <hr/> <p style="text-align: center;">Authorized Agent (Print or Type)</p> <hr/> <p style="text-align: center;">Date</p>	<p>FOR THE STATE:</p> <hr/> <p style="text-align: center;">Signature</p> <p style="text-align: center;">Sean L. Carlson</p> <hr/> <p style="text-align: center;">Name</p> <p style="text-align: center;">Director, Acquisition Services</p> <hr/> <p style="text-align: center;">Title</p> <hr/> <p style="text-align: center;">Date</p>
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**ACQUISITION SERVICES
STATE OF MICHIGAN**

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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: <ul style="list-style-type: none"> • 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/EPSTD	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 1st 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 notwithstanding 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 INSURED(S) 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 procurement costs and damages shall not be considered by the parties to be consequential, indirect, or incidental, and shall not be excluded by any other terms otherwise included in the Contract.



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

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

2. Cancellation For Convenience By the State. The State may cancel this Contract for its convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not 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 Contractor 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/EPSTD 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/EPSTD 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/epl.

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/EPSTD, 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 Contractor's 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 Date³	Period Covered	Instructions/Format
<u>ANNUAL</u>			
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
<u>SEMI-ANNUAL</u>			
Complaint and Grievance	1/30/04	7/1/03 - 12/31/03	MSA 131
	7/30/04	1/1/04 - 6/30/04	
<u>QUARTERLY</u>			
Financial	5/15/04	1/1/04 - 3/31/04	NAIC OFIS
	8/15/04	4/1/04 - 6/30/04	
	11/15/04	7/1/03 - September 30, 2004	
Third Party Collection	5/15/04	1/1/04 - 3/31/04	Report on separate sheet and send with NAIC
	8/15/04	4/1/04 - 6/30/04	
	11/15/04	7/1/03 - September 30, 2004	
<u>MONTHLY</u>			
Claims Processing	30 days after end of month <i>NOT last day of month</i>	•Data covers previous month •i.e., data for 2/04 due by 3/30/04	MSA 2009(E) Revised 9/03
Encounter Data	The 15 th 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

MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2004 – September 30, 2005)

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.

<u>PERFORMANCE AREA</u>	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> • <u>Quality of Care:</u> Childhood Immunization Status 	Fully immunize children who turn two years old during the calendar year.	Combination 1 ≥ 65%	HEDIS report	Annual
<ul style="list-style-type: none"> • <u>Quality of Care:</u> Prenatal Care 	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥ 65%	HEDIS report	Annual
<ul style="list-style-type: none"> • <u>Quality of Care:</u> Blood Lead Testing 	Children at the age of 3 years that have had at least one blood lead test on/before 3 rd birthday	≥ 50%	Blood Lead Registry	Quarterly
<ul style="list-style-type: none"> • <u>Access to care:</u> 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)
<ul style="list-style-type: none"> • <u>Access to care:</u> 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)
<ul style="list-style-type: none"> • <u>Customer Services:</u> Enrollee Complaints 	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < 5 per 1000 member months	Beneficiary/ Provider complaint tracking (BPCT)	Quarterly
<ul style="list-style-type: none"> • <u>Claims Reporting and Processing</u> 	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥90% of clean claims paid within 30 days, and ≤2% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
<ul style="list-style-type: none"> • <u>Encounter Data Reporting</u> 	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
<ul style="list-style-type: none"> • <u>Provider File Reporting</u> 	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		
<i>Clinical Measures - 2004 HEDIS</i>	2003 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	Median	75%	90%
<i>Women's Care</i>					
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%
<i>Living with Illness</i>					
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%
<i>Pediatric Care</i>					
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%
<i>Access to Care - 2004 HEDIS</i>					
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%
<i>Survey Measures - CAHPS</i>		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
<i>Clinical Measures (42.50%)</i>	68	0	Adolescent - Combo 1 (40%)	0.0%	0
<i>Access to Care (12.50%)</i>	20	0	Adolescent Well Care (37%)	0.0%	0
<i>Survey Measures (CAHPS) (13.75%)</i>	22	0	Prenatal Care (75%)	0.0%	0
<i>Accreditation Status (6.25%)</i>	10	0.0	Postpartum Care (55%)	0.0%	0
<i>Legislative Incentive Requirements (25.00%)</i>	40	0	CAHPS Survey Measures		
			** 2 Stars = Statistically Average		
Performance Bonus Total Score	160	0	*** 3 Stars = Statistically Higher than Average		

ATTACHEMENT A
CONTRACTOR'S AWARDED RATES

**State of Michigan Managed Care Rates
Effective October 1, 2004**

Molina Healthcare
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		0.9110		591.65	(1.48)	590.17
16	ABAD 0 - 20	Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
17.1	ABAD 21 - 39	Medicare Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
18.1	ABAD 21 - 39	Medicare Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
17.2	ABAD 21 - 39	Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
18.2	ABAD 21 - 39	Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
19.1	ABAD 40 - 64	Medicare Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
20.1	ABAD 40 - 64	Medicare Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
19.2	ABAD 40 - 64	Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
20.2	ABAD 40 - 64	Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
21.1	ABAD 65 +	Medicare Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
22.1	ABAD 65 +	Medicare Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
21.2	ABAD 65 +	Male	673.56	0.9642		0.9110		591.65	(1.48)	590.17
22.2	ABAD 65 +	Female	673.56	0.9642		0.9110		591.65	(1.48)	590.17
23.1	OAA 0 +	Medicare Male	510.56	0.9642		0.9110	0.758	339.94	(.85)	339.09
24.1	OAA 0 +	Medicare Female	510.56	0.9642		0.9110	0.758	339.94	(.85)	339.09
23.2	OAA 0 +	Male	510.56	0.9642		0.9110	0.758	339.94	(.85)	339.09
24.2	OAA 0 +	Female	510.56	0.9642		0.9110	0.758	339.94	(.85)	339.09
Maternity Case Rate:			3,600.76	0.9642	1.008			3,499.63	(8.75)	3,490.88

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Molina Healthcare
Region 04

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	0.949			190.12	(.48)	189.64
2	TANF < 1	Female	179.67	0.9642	0.949			164.40	(.41)	163.99
3	TANF 1 - 4	Male	74.61	0.9642	0.949			68.27	(.17)	68.10
4	TANF 1 - 4	Female	62.68	0.9642	0.949			57.35	(.14)	57.21
5	TANF 5 - 14	Male	58.09	0.9642	0.949			53.15	(.13)	53.02
6	TANF 5 - 14	Female	50.38	0.9642	0.949			46.10	(.12)	45.98
7	TANF 15 - 20	Male	68.90	0.9642	0.949			63.05	(.16)	62.89
8	TANF 15 - 20	Female	103.85	0.9642	0.949			95.03	(.24)	94.79
9	TANF 21 - 25	Male	96.40	0.9642	0.949			88.21	(.22)	87.99
10	TANF 21 - 25	Female	168.21	0.9642	0.949			153.92	(.38)	153.54
11	TANF 26 - 44	Male	209.91	0.9642	0.949			192.07	(.48)	191.59
12	TANF 26 - 44	Female	228.98	0.9642	0.949			209.52	(.52)	209.00
13	TANF 45 +	Male	455.06	0.9642	0.949			416.39	(1.04)	415.35
14	TANF 45 +	Female	477.73	0.9642	0.949			437.14	(1.09)	436.05
15	ABAD 0 - 20	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
16	ABAD 0 - 20	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
17.1	ABAD 21 - 39 Medicare	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
18.1	ABAD 21 - 39 Medicare	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
17.2	ABAD 21 - 39	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
18.2	ABAD 21 - 39	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
19.1	ABAD 40 - 64 Medicare	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
20.1	ABAD 40 - 64 Medicare	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
19.2	ABAD 40 - 64	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
20.2	ABAD 40 - 64	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
21.1	ABAD 65 + Medicare	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
22.1	ABAD 65 + Medicare	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
21.2	ABAD 65 +	Male	580.20	0.9642		0.9324		521.61	(1.30)	520.31
22.2	ABAD 65 +	Female	580.20	0.9642		0.9324		521.61	(1.30)	520.31
23.1	OAA 0 + Medicare	Male	492.01	0.9642		0.9324	0.848	375.09	(.94)	374.15
24.1	OAA 0 + Medicare	Female	492.01	0.9642		0.9324	0.848	375.09	(.94)	374.15
23.2	OAA 0 +	Male	492.01	0.9642		0.9324	0.848	375.09	(.94)	374.15
24.2	OAA 0 +	Female	492.01	0.9642		0.9324	0.848	375.09	(.94)	374.15
Maternity Case Rate:			3,639.70	0.9642	0.949			3,330.42	(8.33)	3,322.09

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Molina Healthcare
Region 06

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	1.118			223.98	(.56)	223.42
2	TANF < 1	Female	179.67	0.9642	1.118			193.68	(.48)	193.20
3	TANF 1 - 4	Male	74.61	0.9642	1.118			80.43	(.20)	80.23
4	TANF 1 - 4	Female	62.68	0.9642	1.118			67.57	(.17)	67.40
5	TANF 5 - 14	Male	58.09	0.9642	1.118			62.62	(.16)	62.46
6	TANF 5 - 14	Female	50.38	0.9642	1.118			54.31	(.14)	54.17
7	TANF 15 - 20	Male	68.90	0.9642	1.118			74.27	(.19)	74.08
8	TANF 15 - 20	Female	103.85	0.9642	1.118			111.95	(.28)	111.67
9	TANF 21 - 25	Male	96.40	0.9642	1.118			103.92	(.26)	103.66
10	TANF 21 - 25	Female	168.21	0.9642	1.118			181.33	(.45)	180.88
11	TANF 26 - 44	Male	209.91	0.9642	1.118			226.28	(.57)	225.71
12	TANF 26 - 44	Female	228.98	0.9642	1.118			246.83	(.62)	246.21
13	TANF 45 +	Male	455.06	0.9642	1.118			490.54	(1.23)	489.31
14	TANF 45 +	Female	477.73	0.9642	1.118			514.98	(1.29)	513.69
15	ABAD 0 - 20	Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
16	ABAD 0 - 20	Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
17.1	ABAD 21 - 39	Medicare Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
18.1	ABAD 21 - 39	Medicare Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
17.2	ABAD 21 - 39	Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
18.2	ABAD 21 - 39	Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
19.1	ABAD 40 - 64	Medicare Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
20.1	ABAD 40 - 64	Medicare Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
19.2	ABAD 40 - 64	Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
20.2	ABAD 40 - 64	Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
21.1	ABAD 65 +	Medicare Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
22.1	ABAD 65 +	Medicare Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
21.2	ABAD 65 +	Male	580.20	0.9642		0.9938		555.96	(1.39)	554.57
22.2	ABAD 65 +	Female	580.20	0.9642		0.9938		555.96	(1.39)	554.57
23.1	OAA 0 +	Medicare Male	492.01	0.9642		0.9938	0.848	399.79	(1.00)	398.79
24.1	OAA 0 +	Medicare Female	492.01	0.9642		0.9938	0.848	399.79	(1.00)	398.79
23.2	OAA 0 +	Male	492.01	0.9642		0.9938	0.848	399.79	(1.00)	398.79
24.2	OAA 0 +	Female	492.01	0.9642		0.9938	0.848	399.79	(1.00)	398.79
Maternity Case Rate:			3,639.70	0.9642	1.118			3,923.51	(9.81)	3,913.70

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Molina Healthcare
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		1.0330		577.89	(1.44)	576.45
16	ABAD 0 - 20	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
17.1	ABAD 21 - 39 Medicare	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
18.1	ABAD 21 - 39 Medicare	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
17.2	ABAD 21 - 39	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
18.2	ABAD 21 - 39	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
19.1	ABAD 40 - 64 Medicare	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
20.1	ABAD 40 - 64 Medicare	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
19.2	ABAD 40 - 64	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
20.2	ABAD 40 - 64	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
21.1	ABAD 65 + Medicare	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
22.1	ABAD 65 + Medicare	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
21.2	ABAD 65 +	Male	580.20	0.9642		1.0330		577.89	(1.44)	576.45
22.2	ABAD 65 +	Female	580.20	0.9642		1.0330		577.89	(1.44)	576.45
23.1	OAA 0 + Medicare	Male	492.01	0.9642		1.0330	0.848	415.56	(1.04)	414.52
24.1	OAA 0 + Medicare	Female	492.01	0.9642		1.0330	0.848	415.56	(1.04)	414.52
23.2	OAA 0 +	Male	492.01	0.9642		1.0330	0.848	415.56	(1.04)	414.52
24.2	OAA 0 +	Female	492.01	0.9642		1.0330	0.848	415.56	(1.04)	414.52
Maternity Case Rate:			3,639.70	0.9642	1.001			3,512.91	(8.78)	3,504.13

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Molina Healthcare
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		1.0042		652.17	(1.63)	650.54
16	ABAD 0 - 20	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
17.1	ABAD 21 - 39 Medicare	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
18.1	ABAD 21 - 39 Medicare	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
17.2	ABAD 21 - 39	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
18.2	ABAD 21 - 39	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
19.1	ABAD 40 - 64 Medicare	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
20.1	ABAD 40 - 64 Medicare	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
19.2	ABAD 40 - 64	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
20.2	ABAD 40 - 64	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
21.1	ABAD 65 + Medicare	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
22.1	ABAD 65 + Medicare	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
21.2	ABAD 65 +	Male	673.56	0.9642		1.0042		652.17	(1.63)	650.54
22.2	ABAD 65 +	Female	673.56	0.9642		1.0042		652.17	(1.63)	650.54
23.1	OAA 0 + Medicare	Male	510.56	0.9642		1.0042	0.758	374.72	(.94)	373.78
24.1	OAA 0 + Medicare	Female	510.56	0.9642		1.0042	0.758	374.72	(.94)	373.78
23.2	OAA 0 +	Male	510.56	0.9642		1.0042	0.758	374.72	(.94)	373.78
24.2	OAA 0 +	Female	510.56	0.9642		1.0042	0.758	374.72	(.94)	373.78
Maternity Case Rate			3,600.76	0.9642	0.985			3,419.78	(8.55)	3,411.23

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Molina Healthcare
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		0.9476		615.42	(1.54)	613.88
16	ABAD 0 - 20	Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
17.1	ABAD 21 - 39	Medicare Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
18.1	ABAD 21 - 39	Medicare Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
17.2	ABAD 21 - 39	Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
18.2	ABAD 21 - 39	Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
19.1	ABAD 40 - 64	Medicare Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
20.1	ABAD 40 - 64	Medicare Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
19.2	ABAD 40 - 64	Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
20.2	ABAD 40 - 64	Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
21.1	ABAD 65 +	Medicare Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
22.1	ABAD 65 +	Medicare Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
21.2	ABAD 65 +	Male	673.56	0.9642		0.9476		615.42	(1.54)	613.88
22.2	ABAD 65 +	Female	673.56	0.9642		0.9476		615.42	(1.54)	613.88
23.1	OAA 0 +	Medicare Male	510.56	0.9642		0.9476	0.758	353.60	(.88)	352.72
24.1	OAA 0 +	Medicare Female	510.56	0.9642		0.9476	0.758	353.60	(.88)	352.72
23.2	OAA 0 +	Male	510.56	0.9642		0.9476	0.758	353.60	(.88)	352.72
24.2	OAA 0 +	Female	510.56	0.9642		0.9476	0.758	353.60	(.88)	352.72
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 # **071B5200018**

ATTACHMENT B

MOLINA HEALTHCARE OF MICHIGAN

APPROVED SERVICE AREAS

Region 1

Wayne

Region 4

Allegan, Benzie, Ionia, Kent, Lake, Manistee, Mason, Mecosta, Montcalm,
Muskegon, Newaygo, Oceana, Osceola, Ottawa, Wexford/Missaukee

Region 6

Genesee

Region 7

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

Region 9

Macomb

Region 10

Oakland