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

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

CHANGE NOTICE NO. 12
to
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
UnitedHealthCare Community Plan, Inc.	Dennis Mouras, President	dmouras@uhc.com
26957 Northwestern Hwy, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Southfield, MI 48033	(248) 331-4269	

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

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**

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

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

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

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

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$1,285,677,041.00	$5,446,897,471.79

Effective April 1, 2014, the CCI has been updated, the attached Contract changes for Mid Fiscal Year 2014 are hereby incorporated into this Contract and the Contract is increased by $1,285,677,041.00. The Contract expiration date has been revised to September 30, 2015.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on March 25, 2014.

Change Notice Number _____12_____
Contract Number_____071B0200012_____

FOR THE CONTRACTOR:	**FOR THE STATE:**
United HealthCare Community Plan, Inc.	
Firm Name	Signature
	Tom Falik, Services Division Director
Authorized Agent Signature	Name/Title
	DTMB Procurement
Authorized Agent (Print or Type)	Enter Name of Agency
Date	Date

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

Section A: MDCH Initiated Changes

1. Medicare HMO exclusion

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

   - Persons with commercial HMO/PPO coverage

2. Marketing Incentives

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

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

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

   The member incentives must meet all requirements for incentives.

3. Tobacco Cessation

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

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

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

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

4. Annual Report

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

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

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

5. Clarification of Excluded Services

Definitions Section is hereby amended to include the following:

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

6. Provider Incentives for 4 X 4

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

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

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

Section B: Healthy Michigan Plan Changes:

7. Definitions

Definitions section is hereby amended to include the following:

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

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

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

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

(16) Twenty Visit Mental Health Outpatient Benefit

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

9. Healthy Michigan Plan Enrollees Transitioning from Adult Benefit Waiver

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

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

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

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

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

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

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

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

(5) Healthy Michigan Plan Enrollee Contributions

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

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

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

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

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

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

- Expenditures from the account

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

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

11. Contributions and MI Health Account – MIS Capabilities

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

(1) MIS Capability

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

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

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

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

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

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

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

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

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

(2) Enrollment Files

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

(3) Data Accuracy

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

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

(4) Automated Contact Tracking System

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

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

(5) Health Information Technology

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

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

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

(6) PROM-BMP

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

12. Contributions and MI Health Account – Remedies

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

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

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

13. Enrollment

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

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

14. Co-payments

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

(5) Co-Payments

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

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

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

15. Healthy Behaviors and Health Risk Assessment

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

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

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

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

- Immunization status

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

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

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

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

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

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

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

17. Advance Directive

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

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

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

18. Reporting

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

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

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

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

- Medicaid eligible persons enrolled under the Healthy Michigan Plan

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

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

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

21. Risk Mitigation

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

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

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

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

CHANGE NOTICE NO. 11
to
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
UnitedHealthCare Community Plan, Inc.	Don W. Schmidt, President	don_w_schmidt@uhc.com
26957 Northwestern Hwy, Suite 400	TELEPHONE	CONTRACTOR #, MAIL CODE
Southfield, MI 48033	(248) 331-4269	

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

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**

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

DESCRIPTION OF CHANGE NOTICE:

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

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$4,161,220,429.79

Effective October 1, 2013, the attached Contract changes for Fiscal Year 2014 are hereby INCORPORATED into this Contract.

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

Per agency and vendor agreement, and DTMB Procurement approval.

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

Section A: MDCH Initiated Changes

1. Contract Term

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

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

2. Transportation

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

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

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

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

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

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

- Chronic and ongoing treatment

- Prescriptions
- Medical supplies
- Visits for medical care

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

3. Tobacco Cessation

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

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

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

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

4. Health Indicator Incentives

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

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

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

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

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

(1) MIS Capability

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

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

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

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

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

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

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

i. Member enrollment, disenrollment, and capitation payments, including the capability of reconciling enrollment and capitation payments received
ii. Utilization
iii. Provider enrollment
iv. Third party liability activity
v. Claims payment
vi. Grievance and appeal tracking, including tracking for CSHCS enrollees separately

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

The Contractor must:

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

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

5. Notification of Availability of Translation Services

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

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

6. Data Sharing

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

(5) Electronic Data Exchange

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

7. Measurement Data

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

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

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

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

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

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

(7) Medicaid Health Equity Project

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

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

(9) HEDIS Member-Level Data

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

(10) Provider Race/Ethnicity Reporting

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

(11) Other Data Sources

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

8. Reporting

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

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

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

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

9. Beneficiary Monitoring Program

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

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

10. FQHC

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

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

11. Sanctioned and Debarred Providers

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

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

12. Definition of Potential Enrollee

Revise Definition and Terms to include the following:

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

13. Release of Report Data

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

B. Release of Report Data

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

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

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

Section C: Appendices and Attachments:

14. Appendices

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

15. Attachments

Attachment B is hereby amended to include the following:

Fiscal Year 2014

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

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

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

Accreditation Status - 2014	**Accredited or Conditional as of 12/31/13 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/13 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/13 (10 Pts)**
Org Name (Date of visit)			

Total Member Months of Enrollment by Age and Sex - HEDIS 2014	**0**

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

CAHPS Survey Measures

based on 2013 NCQA Quality Compass Medicaid Percentiles

Appendix 2

DCH Financial Monitoring Standards

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

Appendix 3
2014 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

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

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

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

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

MEDICAID MANAGED CARE
Medicaid Health Plans

Appendix 4 – PERFORMANCE MONITORING STANDARDS

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

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

The Performance Monitoring Standards address the following performance areas:

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

For each performance area, the following categories are identified:

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

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

Appendix 5
2014 DCH P4P Bonus
Benefits Monitoring Program

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

Change Notice Number 11

Contract Number 071B0200012

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

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

September 13, 2013

CHANGE NOTICE NO. 10
to
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
UnitedHealthCare Community Plan, Inc. 26957 Northwestern Hwy, Suite 400 Southfield, MI 48033	Don W. Schmidt, President TELEPHONE (248) 331-4269	don_w_schmidt@uhc.com CONTRACTOR #, MAIL CODE

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

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
October 1, 2009	September 30, 2012	3, one year	September 30, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:

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

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$738,077,357.00	$4,161,220,429.79

Effective September 13, 2013, the attached Contract changes are hereby INCORPORATED into this Contract. Contract is also extended using a contract option year; new end date is September 30, 2014. Contract is increased by $738,077,357.00. All other terms, conditions, specifications, and pricing remain the same. Per agency and vendor agreement, DTMB Procurement approval and the approval of the State Administrative Board on September 13, 2013.

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

16. Contract Objectives

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

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

17. EPSDT/Autism

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

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

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

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

18. Beneficiary Monitoring Program

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

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

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

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

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

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

(4). Beneficiary Monitoring Program

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

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

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

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

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

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

(6) PROM-BMP

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

19. Enrollee Education

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

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

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

20. QI Director Requirements

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

(3) Quality Improvement and Utilization Director

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

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

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

21. ACA Primary Rate Increase

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

(9) ACA Primary Rate Increase

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

22. PCP Submission File

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

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

23. Revised Appendix 5

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

24. Revised Attachment B

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

Contractor's Awarded Rates

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

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

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

Health Plan Name	FY 13 Performance Bonus Template		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
Clinical Measures - 2013 HEDIS	**2012 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Women's Care					
Breast Cancer-Combined Rate		0	0.0%	0.0%	0.0%
Cervical Cancer		0	0.0%	0.0%	0.0%
Chlamydia - Combined Rate		0	0.0%	0.0%	0.0%
Prenatal Care		0	0.0%	0.0%	0.0%
Postpartum Care		0	0.0%	0.0%	0.0%
Living with Illness					
HbA1c Test		0	0.0%	0.0%	0.0%
Controlling High Blood Pressure		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds - Combined Rate		0	0.0%	0.0%	0.0%
Appropriate Asthma Meds- Ages 5-11		0	0.0%	0.0%	0.0%
Adult BMI		0	0.0%	0.0%	0.0%
Pediatric Care					
Well Child Visits					
0-15 Months - 6+ visits		0	0.0%	0.0%	0.0%
3-6 Years		0	0.0%	0.0%	0.0%
Adolescent		0	0.0%	0.0%	0.0%
Other					
Children BMI		0	0.0%	0.0%	0.0%
Childhood - Combo 3		0	0.0%	0.0%	0.0%
Blood Lead		0	0.0%	0.0%	0.0%
Appropriate Treatment for Children with URI		0	0.0%	0.0%	0.0%
Access to Care - 2013 HEDIS	**2013 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%**	**75%**	**90%**
Children					
12-24 Months		0	0.0%	0.0%	0.0%
25 Months - 6 Years		0	0.0%	0.0%	0.0%
7-11 Years		0	0.0%	0.0%	0.0%
12-19 Years		0	0.0%	0.0%	0.0%
Adult					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
Survey Measures - CAHPS	**Last CAHPS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**50%****	**75%****	**90%****
Getting Needed Care - Adult		0	0.0%	0.0%	0.0%
Getting Care Quickly - Adult		0	0.0%	0.0%	0.0%
Health Plan Rating - Adult		0	0.0%	0.0%	0.0%

Advising Smokers and Tobacco Users to Quit	0	0.0%	0.0%	0.0%

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

Accreditation Status - 2013	**Accredited or Conditional as of 12/31/12 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/12 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/12 (10 Pts)**
Org Name (Date of visit)			

Total Member Months of Enrollment by Age and Sex - HEDIS 2013	**0**

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

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

CAHPS Survey Measures

**** based on 2012 NCQA Quality Compass Medicaid Percentiles.**

Health Plan
2013 CSHCS Focus Study

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

Change Notice Number 11
Contract Number 071B0200012

2013 Performance Bonus
Focus Study Point Allocation

Access to Care (CM)

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

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

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

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

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

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

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

IT Systems (QA)

6. **5 total pts**

A. IT Systems *2 pts.*

- ☐ generate measures of utilization, access and quality of care
- ☐ demonstrate tracking ability
- ☐ review data sharing activities

Quality of Care (QA)

B. Demonstrate that measures applied to the pediatric population as a whole are being applied to the CSHCS population. Data for this subpopulation should be available

for specific analysis to see if the basic HEDIS measures are being met for the children/youth. *2 pts.*

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

Member Rights (Grievance & Appeals) (CM)

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

- ☐ Evidence of process to analyze and report grievances and appeals *3 pts*
  - ☐ review grievance & appeals reports and logs
- ☐ Rate of grievance and appeals for CSHCS enrollees *1 pt*
- ☐ Rate of appeals for CSHCS enrollees specifically related to prior authorization *1 pt*

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

Appendix 5
2013 DCH P4P Bonus
Healthcare for a Diverse Membership

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

Appendix 5
2013 Bonus Measures Template
DCH Focus - CSHCS

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

Form No. DTMB-3521 (Rev. 4/2012)

AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

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

CHANGE NOTICE NO. 9
to
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
UnitedHealthCare Community Plan, Inc. 26957 Northwestern Hwy, Suite 400 Southfield, MI 48033	David Livingston, President TELEPHONE (248) 331-4269	dlivingston@uhc.com CONTRACTOR #, MAIL CODE

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

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**

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

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

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

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

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$0.00	$3,423,143.072.79

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

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

Change Notice Number 11
Contract Number 071B0200012

Per agency and vendor agreement and DTMB Procurement approval.

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

Change Notice Number 9
Contract Number 071B0200012

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

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

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

July 31,2012

CHANGE NOTICE NO. 8

to

CONTRACT NO. 071B0200012

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
UnitedHealthCare Community Plan, Inc. 26957 Northwestern Hwy, Suite 400 Southfield, MI 48033	David Livingston, President	dlivingston@uhc.com
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(248) 331-4269	

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

CONTRACT SUMMARY:

DESCRIPTION: **Comprehensive Health Care Program – Department of Community Health (Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS	CURRENT EXPIRATION DATE
October 1, 2009	September 30, 2012	3, one year	September 30, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ YES ☒ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:

OPTION EXERCISED: ☐ NO ☐ YES	IF YES, EFFECTIVE DATE OF CHANGE:	NEW EXPIRATION DATE:

Effective June 1, 2012, the attached Contract Changes for Fiscal Year 2012 are hereby INCORPORATED into this Contract (see attachment). Effective October 1, 2012, this Contract is hereby INCREASED by $905,404,756.00. All other terms, conditions, pricing and specifications remain the same.

Per Contractor/DCH agreement, DTMB Procurement approval and the approval of the State Administrative Board on July 24, 2012.

VALUE/COST OF CHANGE NOTICE:	$905,404,756.00
ESTIMATED REVISED AGGREGATE CONTRACT VALUE:	$3,423,143.072.79

Contract Changes for Fiscal Year 2012

Contract Changes are Effective 06/01/2012

1. Provider Payments

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

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

Rationale: Required to implement the June 2012 rate changes.

2. Hospital Payments

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

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

Rationale: Required to implement the June 2012 rate changes.

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

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **May 16, 2012**
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 7
TO
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **UnitedHealthCare Community Plan, Inc.** **26957 Northwestern Hwy., Suite 400** **Southfield, MI 48033** **dlivingston@uhc.com**	TELEPHONE (248) 331-4269 **David Livingston, President** BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Greg Rivet (517) 335-5096 **Comprehensive Health Care Program – Department of Community Health** **(Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

Effective January 1, 2012, United Healthcare Great Lakes Health Plan will change its name to UnitedHealthCare Community Plan, Inc.

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

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

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

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

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Procurement approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $2,517,738,316.79

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

3. Appendices

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

Rationale: Updated for fiscal year 2012

4. Health Education

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

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

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

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

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

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

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

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

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

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

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

CC. Marketing

(1) General Information

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

(4) Marketing materials

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

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

Attachment C

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

Appendix 3

2012 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS

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

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

Notes

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

EPSDT Settlement Reporting Requirements

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

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

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

Appendix 4 – PERFORMANCE MONITORING STANDARDS

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

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

The Performance Monitoring Standards address the following performance areas:

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

For each performance area, the following categories are identified:

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

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

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

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

Appendix 5
2012 Bonus Template - DCH Focus PCMH

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

Appendix 5
2012 DCH P4P Bonus

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

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

Accreditation Status - 2011	**Accredited or Conditional as of 12/31/11 (7 pts)**	**NCQA New Plan or URAC Provisional Accreditation as of 12/31/11 (8.5 points)**	**Excellent/ Commendable or Full Accreditation as of 12/31/11 (10 Pts)**
Org Name (Date of visit)			

Total Member Months of Enrollment by Age and Sex - HEDIS 2010	**0**

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

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

CAHPS Survey Measures

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

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

1. Chiropractic Services

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

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

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

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

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

CHANGE NOTICE NO. 6
TO
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 331-4269 **David Livingston, President**
UnitedHealthcare Community Plan, Inc. **26957 Northwestern Hwy., Suite #400** **Southfield, MI 48033** **dlivingston@uhc.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Penny Saites (517) 335-5036 **Comprehensive Health Care Program – Department of Community Health** **(Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

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

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

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

AUTHORITY/REASON:

Per Contractor/DCH agreement and DTMB/Procurement approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $2,517,738,316.79

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

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

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B0200012
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 331-4269 **David Livingston, President**
United Healthcare Great Lakes Health Plan **26957 Northwestern Hwy., Suite 400** **Southfield, MI 48033** **dlivingston@glhp.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Penny Saites (517) 335-5036 **Comprehensive Health Care Program – Department of Community Health** **(Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Ottawa, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, Van Buren, Wayne)**	
CONTRACT PERIOD: **3 yrs. + 3 one-year options** From: **October 1, 2009** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

NATURE OF CHANGE(S):

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

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

Effective September 15, 2011, this contract is hereby INCREASED by $2,303,452,602.50.

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

AUTHORITY/REASON:

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

INCREASE: $2,303,452,602.50

TOTAL REVISED ESTIMATED CONTRACT VALUE: $2,517,738,316.79

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

Section One

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

1. Definitions

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

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

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

2. Enrollee Acceptance

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

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

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

3. Notification of Disenrollment Rights

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

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

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

4. Enrollee Requests for Disenrollment

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

a. Enrollee's current health plan does not, because of moral or religious objections, cover the service the enrollee seeks and the enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
b. Lack of access to providers or necessary specialty services covered under the Contract. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor.
c. Concerns with quality of care.

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

5. Continuation of Services

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

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

Rationale: Required by CMS per State Medicaid Manual 2086.6.B

6. Covered Services

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

(1) Covered Services

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

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

Rationale: Required by CMS per 42 CFR 438.210(a)(4)

7. Emergency Services

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

(1) *Emergency Services*

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

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

(a) Emergency Transportation

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

(b) Emergency Professional Services

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

(c) Emergency Facility Services

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

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

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

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

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

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

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

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

8. Blood Lead Testing

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

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

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

9. Oral and Written Interpretation

Delineate oral interpretation services apply to all non-English languages, not just those languages that meet the definition of prevalent language under the Contract (xxiii and xxiv). MI added the word "All" at the beginning of 1.022(H)(1) and separated the requirement for oral interpretation services and written materials into two criteria under 1.022(H)(3)(b) Additionally, MI added the following sentences to the second paragraph of 1.022(H)(1):

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

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

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

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

10. Women's Routine and Preventive Health Services

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

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

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

11. Enrollee Right To Request Information

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

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

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

12. Certain Non-Covered Services

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

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

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

13. Toll Free Number for Grievance and Appeals

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

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

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

14. Grievance and Appeal Requirements

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

I. Grievance and Appeal Policies and Procedures

(1) *Contractor Grievance/Appeal Policy Requirements*

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

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

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

(2) *Grievance and Appeal Procedure Requirements*

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

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

(3) *Notice to Enrollees of Grievance Procedure*

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

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

(4) *Notice to Enrollees of Appeal Procedure*

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

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

When the Contractor makes a decision subject to appeal, as defined in this Contract, the Contractor must

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

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

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

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

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

(5) *Adverse Action Notice*

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

(a) The action the Contractor or Subcontractor has taken or intends to take
(b) The reasons for the action
(c) The enrollee's or provider's right to file an appeal
(d) An explanation of the Contractor's appeal process
(e) The enrollee's right to request a Fair Hearing
(f) The circumstances under which expedited resolution is available and how to request it
(g) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services

Written adverse action notices must also meet the following criteria:

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

(6) *State Medicaid Appeal Process*

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

(7) *Expedited Appeal Process*

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

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

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

15. For Cause Disenrollment

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

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

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

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

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

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

16. Enrollee Rights

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

Enrollee Rights

The Contractor must develop and maintain a written policy regarding enrollee rights. These rights must be communicated to enrollees in the member handbook. The enrollee rights must include, as a minimum, the enrollee's right to:

a. Confidentiality
b. Participate in decisions regarding her health care, including the right to refuse treatment and express preferences about treatment options
c. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

d. Request and receive a copy of her medical records, and request that they be amended or corrected
e. Be furnished healthcare services consistent with this Contract and State and federal regulations
f. Be free to exercise her rights without adversely affecting the way the Contractor, providers or the State treats the enrollee
g. Be free from other discrimination prohibited by State and federal regulations

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

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

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

17. Anti-gag Clause

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

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

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

18. Hospital Contracts

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

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

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

19. Provider Network

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

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

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

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

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

The Contractor must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and Subcontractors at the time they enter into a contract:

(a) The enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing
(b) The enrollee's right to file grievances and appeals and their requirements and timeframes for filing
(c) The availability of assistance in filing
(d) The toll-free numbers to file oral grievances and appeals
(e) The enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Contractor's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits

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

21. Dissemination of Clinical Practice Guidelines

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

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

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

22. Enrollee Notification of Extension of Utilization Time Frame

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

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

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

23. Sanctions

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

- Financial requirements including, but not limited to, failure to comply with physician incentive plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program.
- Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

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

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

- Civil monetary penalties in the following specified amounts:
  - A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
  - A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
  - A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

- A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging co-payments in excess of the amounts permitted under the Medicaid program. The State will deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).
- Appointment of temporary management for a Contractor as provided in 42 CFR 438.706. If a temporary management sanction is imposed, DCH will work concurrently with OFIR.
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
- Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the sanction.
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

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

24. NPI Reporting

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

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

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

25. Grievance and Appeal Reporting

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

> (7) *Quarterly Grievance and Appeal Report*

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

Section Two

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

26. Definitions

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

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

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

27. Rename Section

Section 1.022(O)(2) was renamed to “Reporting of Fraud and Abuse”

Rationale: Clarification of purpose of the section

28. Monitoring Time Lines

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

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

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

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

Rationale: Clarification of time lines

29. Prohibited Affiliations

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

(3) *Prohibited Affiliations with Individuals Debarred by Federal Agencies*
The following individuals are covered under this Section:

(a) Providers – All contracted providers
(b) Provider employees – Directors, officers, partners, agents, all employees, and persons with beneficial ownership of more than five percent of the entity's equity
(c) Contractor employees – Directors, officers, partners, agents, all employees, and persons with beneficial ownership of five percent or more of the entity's equity

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

Pursuant to Section 42 CFR 438.610, a Contractor may not knowingly have a director, officer, partner, managing employee, or person with beneficial ownership of five percent or more of the entity's equity who is currently debarred or suspended by any State or federal agency. The Contractor is also prohibited from having a contractual, employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State.

The review for individuals that are debarred or suspended by any State or federal agency must be performed when the Contractor initiates employment or provider enrollment. The Contractor must have procedures for the periodic review of covered individuals to ensure that none become debarred or suspended by any state or federal agency during the course of employment or contractual relationship.

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

(1) *Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases.*
(2) *Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the General Services Administration's Excluded Parties List System (EPLS), the Medicare Exclusion Database (MED), and any such other databases as the Secretary of HHS may prescribe.*
(3) *(a) Consult appropriate databases to confirm identity upon enrollment and reenrollment*

(b) Check the LEIE and EPLS and any such other databases as the Secretary of HHS may prescribe, no less frequently than monthly.
(4) *Check the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List and the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR) as updates are published.*

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

30. Disclosure of Criminal Convictions

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

> (4) *Disclosure of Criminal Convictions*
> Before entering into or renewing a provider agreement, or at any time upon written request by DCH, covered individuals (described in subsection 1.022(O)(3)(a and b), must also disclose criminal convictions related to federal healthcare programs. Within 20 working days of receipt of the disclosure, the Contractor must notify the Inspector General of HHS. The Contractor will promptly notify the Inspector General of HHS and DCH of any action it takes in respect to its provider's enrollment.
>
> Before entering into or renewing a provider agreement, or at any time upon written request by DCH, covered individuals (described in subsection 1.022(O)(3)(c) must also disclose criminal convictions related to federal healthcare programs. Within 20 working days of receipt of the disclosure, DCH will notify the Inspector General of HHS. DCH will promptly notify the Inspector General of HHS of any action it takes with respect to the Contractor's enrollment. In accordance with section 2.155 of this Contract, DCH may refuse to enter into or renew a Contract with Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. Additionally, DCH may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under this section.

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

31. Disclosures Required by the Contractor

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

> (5) Disclosures Required of Contractors
> All required disclosures under this subsection must be made to DCH or CMS in the format developed by the State. Failure to provide required information may lead to sanctions including withholding of capitation payment. Because federal financial participation is not available for entities that do not comply with disclosures, DCH may withhold capitation from the Contractor for services provided during the period beginning on the day following the date the information was due to DHS and ending on the day before the date on which the information was supplied.
>
> a. Ownership and Control of Contractor – Contractors must disclose the following information for any and all persons (individual or corporation) with an ownership or control interest in the Contractor :
>
> - Name and Address. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
> - The date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor.
> - Tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by the Contractor in which the Contractor has a five percent or more interest.
> - The name, address, date of birth, the Social Security Number of managing employee of the Contractor. For purposes of this subsection, managing employees are the following: President/Chief Executive Officer, Chief Operating Officer, Chief Financial Officer and Chief of Management Information Systems.
> - Information regarding relationships to others with ownership or control interest. The Contractor must report if the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling
> - Information regarding related organizations. The Contractor must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which the Contractor has an ownership or control interest.
>
> b. Disclosures for Ownership and Control of the Contractor must be made at the following times:
>
> - Proposal submission in accordance with the State's procurement process.
> - Contract execution

- Contract extension
- Within 35 days of a change in ownership of the Contractor

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

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

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

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

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

(6) Disclosures Required of Contracted Providers and Fiscal Agents

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

b. Ownership and Control of Network Provider (includes fiscal agent or disclosing entity on behalf of network provider)
   - Name and Address. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
   - The date of birth and Social Security Number (in the case of an individual) or tax identification number (in the case of a corporation) with an ownership or control interest in the network provider's entity
   - Tax identification number of a corporate entity with an ownership or control interest in any subcontractor utilized by the network provider in which the network provider has a five percent or more interest.
   - The name, address, date of birth, the Social Security Number of the agent or managing employee of the network provider's entity.
   - Information regarding relationships to others with ownership or control interest. The network provider must report if the person (individual or corporation) with an ownership or control interest in the network provider's entity is related to another person with ownership or control interest in the network provider's entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling
   - Information regarding related organizations. The network provider must report the name of any other disclosing entity (or fiscal agent or managed care entity) in which the network provider has an ownership or control interest.

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

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

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

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

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

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

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

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

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

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

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

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

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

- community centers, schools and daycare centers

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

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

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

37. Key Personnel

Modify Contract to replace “Cheryl Bupp” with “Kathleen Stiffler”