Form No. DTMB-3521 (Rev. 2/2015)
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
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 13

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	PHONE	VENDOR TAX ID # (LAST FOUR DIGITS ONLY)
Southfield, MI 48033	(248) 331-4269	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Kevin Dunn	(517) 335-5096	dunnk3@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	(517) 284-7017	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, 1 Yr. Options	September 30, 2015
PAYMENT TERMS	F.O.B.	SHIPPED TO	
N/A	N/A	N/A	

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ 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 EXTENSION/OPTION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☐	☒	3 months	December 31, 2015

CURRENT VALUE	VALUE/COST OF CHANGE NOTICE	ESTIMATED REVISED AGGREGATE CONTRACT VALUE
$5,446,897,471.79	$420,456,747.00	$5,867,354,218.79

DESCRIPTION:
Effective April 28, 2015, the attached documents are hereby incorporated into this contract and the contract increased by $420,456,747.00. The contract expiration date has been revised to December 31, 2015.

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 April 28, 2015.

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.
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
2015 Reporting Requirements for Medicaid Health Plans

All reports must be **shared** electronically via the **DCH File Transfer Application**.
Exceptions are the encounter data, provider file, and PCP Submission file which are submitted electronically via the DEG.

Report Reference	Due Date	Period Covered	Instructions/Format
Annual Submissions			
Consolidated Annual Report	3/15/15	1/1/14 – 12/31/14	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 DIFS, and Statement of Actuarial Opinion are due with the annual report on 3/15/15). *NOTE: The Management Discussion and Analysis is due 4/15/15 and the Audited Financial Statements are due 6/15/15.* • Health Plan Data Certification Form (MSA 2012 (03/13)). • 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) • Provider Manual, Certificate of Coverage, Member Handbook (WR only) • 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			
Michigan Medicaid Tobacco Cessation Benefits Grid	6/15/15	Current, up-to-date, per contract	1.022 F (20) Use MI Medicaid Tobacco Cessation Benefits Grid as provided by DCH in January
Management Discussion and Analysis for Annual Financial	4/15/15	1/1/14 – 12/31/14	Contract 1.042 A(2)
Audited Financial Statements	6/15/15	1/1/14 – 12/31/14	NAIC, DIFS
QIP Annual Evaluation and Work Plan	6/15/15	Current, Approved 2014 Evaluation, 2015 Work Plan	Electronic Format; Contract 1.022 Z(1-3)
Medicaid Health Equity Template	8/15/15	1/1/14 – 12/31/14	Use the template provided by DCH in March
HEDIS® Compliance Audit – Final Audit Report	8/15/15	1/1/14 – 12/31/14	NCQA formatted, electronic copy
HEDIS® IDSS	7/15/15	1/1/14 – 12/31/14	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			
Financial	5/15/15 8/15/15 11/15/15	1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	NAIC and DIFS

Report Reference	Due Date	Period Covered	Instructions/Format
Grievance/Appeal	1/30/15 4/30/15 7/30/15 10/30/15	10/1/14 – 12/31/14 1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	MSA 131 (11/11), Grievance & Appeal Report
Third Party Collection	5/15/15 8/15/15 11/15/15	1/1/15 – 3/31/15 4/1/15 – 6/30/15 7/1/15 – 9/30/15	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 2/15 due by 3/30/15	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/15 due by 2/15/15	837 Format NCPDP Format
Provider Files (4275)	Friday before the last Saturday of each month	• Submit all providers contracted with the plan on the date of submission • Submit four files, utilizing the provider voluntary ID for Benefit Plans: *MA-MC *CSHCS-MC *MME-MC *HMP-MC	4275 layout and file edits distributed by DCH
PCP Submission Files (5284)	Weekly if PCP name is NOT on ID card; otherwise at least one monthly	•Submit all new and end-dated PCP relationships since the previous submission •Submit a complete refresh file during the time period required by DCH	5284 layout and file edits distributed by DCH
Health Risk Assessment File (5708)	At least one file prior to the 20th of each month	Once the initial appointment is complete, plans will have 60 days to transmit the associated HRA data to DCH via the 5708 file layout.	5708 Layout and file edits distributed by DCH

MEDICAID MANAGED CARE
Medicaid Health Plans
(Contract Year October 1, 2014 – September 30, 2015)

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 measurement Period.	Informational Only	MDCH Data Warehouse	Quarterly
• **Quality of Care:** Elective Delivery	Pregnant women with elective vaginal deliveries or elective cesarean sections at between 37 and 39 weeks completed gestation.	Informational Only	MDCH Data Warehouse	Quarterly
• **Quality of Care:** Postpartum Care	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	Informational Only	MDCH Data Warehouse	Quarterly
• **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	≥81% continuous enrollment	MDCH Data Warehouse	Quarterly
• **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	Informational Only	MDCH Data Warehouse	Quarterly
• **Access to care:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during measurement period.	Informational Only	MDCH Data Warehouse	Quarterly
• **Access to care:** Adult Access to Preventive/Ambulatory Health Services	Adults 20+ years who had an ambulatory or preventive visit during the measurement period	Informational Only	MDCH Data Warehouse	Quarterly

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 processed within 30 days, ≤1% of ending inventory over 45 days old; ≤12% 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 Accurate submission	MI Enrolls	Monthly

Appendix 5
2015 Bonus Measures Template
DCH Pay for Performance—Healthy Michigan Plan Systems

In an effort to ensure consistency among plans in tracking and reporting FY16 metrics related to Healthy Michigan Plan, the FY15 Focus Bonus is a review of processes, procedures, and systems that will be utilized in the generation of these metrics.

There are three domains of review that draw from 40% of the total capitation withhold pool: 1) Cost sharing and incentives. 2) Access to Care. 3) Health Risk Assessment.

The Value Added section draws from 10% of the total capitation withhold pool.

Instructions: Email all documents to Nneka LaBon at labonn@michigan.gov. The subject line should be labeled as 2015P4P- Category name (ex. 2015P4P – Access).

Category	Criteria/Deliverables
1. **Cost Sharing and Incentives** (15 points)	1. October 1, 2014. A contract with the MI Health Account vendor, Maximus, will be signed and in place. 2. April 1, 2015. Description of ongoing monitoring of MI Health Account vendor, Maximus, in relation to: a. Required three reports related to cost sharing b. Member education on cost-sharing responsibilities including welcome letter, statements, and payment coupons c. Investigation of MIHealth Account complaints received by Maximus 3. December 1, 2014. Member Incentive. A Policy/Procedure will be submitted to DCH that outlines the MHP process for members receiving an incentive. This will include, at a minimum, the following: a. The process of receiving and processing completed Health Risk Assessments and identifying which members are eligible for incentives including HRAs completed during the FFS period b. The process to 'flag' those members for an incentive in the MIS/administrative system c. A congratulatory letter that is approved by DCH that informs members that they have earned an incentive and turnaround time for distribution of the letter and/or gift card. 4. December 1, 2014. Provider incentive. A Policy/Procedure will be submitted to DCH that outlines the MHP process for physician incentives. 5. Encounter Quality Initiative submissions in accordance with dates provided by MDCH. a. Follow-up explanation of variances for each submission in a summary email to MDCHEncounterData@michigan.gov b. Available for at least one annual site visit from DCH staff
2. **Access to Care** (10 points)	1. December 1, 2014. Assistance with scheduling first primary care appointment. Documentation will be submitted to DCH that outlines how MHP encourages and assists members with scheduling and attending first primary care appointment. 2. April 1, 2015. Report of transportation services provided to HMP members. MDCH will pull this from encounter data.

	3. June 1, 2015. Network adequacy. Number of PCPs with evening and weekend appointments available. MDCH will pull this from the 4275 file.
3. **Health Risk Assessment** (15 points)	1. October 20, 2014. First HRA survey file (5708) to DCH. MHP will submit a monthly HRA survey file (5708) to DCH by the 20th of each month. 2. December 1, 2014. HRA survey file (5700) from Maximus. A Policy/Procedure will be submitted to DCH that outlines the MHP process for receiving the HRA survey file (5700). 3. December 1, 2014. HRA survey file (5708) to DCH. A Policy/Procedure will be submitted to DCH that outlines the MHP process for submitting the HRA survey file (5708) and including process for resending record rejections identified in HRA survey error file (5725). 4. December 1, 2014. Member Education. A Policy/Procedure will be submitted to DCH that outlines the MHP process for educating members about the Health Risk Assessment. This must include HRA in welcome packet, member education about healthy behaviors incentives and HRA information in new member call script. 5. March 1, 2015. Assistance with Healthy Behaviors. A Policy/Procedure will be submitted to DCH that outlines the MHP process for identifying members who have identified health risk reduction goals on HRA and outreach to these members. a. Report of members reached and documentation of support services, education, or other interventions provided by MHP.
4. **Value added** (10 points)	Cost Sharing and Incentives Value Added 1. Documentation of additional efforts to inform members of copays and contribution responsibilities in handbook, newsletter, etc. 2. Documentation of additional efforts to encourage members to meet their cost-sharing obligations beyond responsibilities outlined in contract with the MI Health Account vendor Access to Care Value Added 3. Documentation of assistance with picking a Primary Care Provider offered in initial outreach call 4. Documentation of assistance with transportation needs offered in initial outreach call HRA Value Added 5. Documentation of provider education on correct Health Risk Assessment completion, including accessing and submitting the HRA information

Contract Changes FY 2015
Contract Changes are Effective 10/01/2014

1. Tobacco Cessation

Section 1.022(F)(20), final paragraph is hereby replaced in its entirety with the following:

The Contractor may not place prior authorization requirements on over-the-counter agents or prescription inhalers or nasal sprays. Further, DCH encourages the Contractor to have no co-payment or prior authorization requirements for the remaining tobacco cessation treatments. 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 other than inhalers or nasal sprays. DCH retains the right to review and approve any limits or prior authorizations that the Contractor implements for this benefit.

2. Health Education

The following paragraph is hereby removed from 1.022H(1) Enrollee Services – General

Written and oral materials directed to enrollees, relating solely to health education, may be filed with DCH a minimum of 10 business days prior to use. If DCH does not respond to the filing within 10 business days the material is deemed approved.

3. Healthy Michigan Plan Enrollee Healthy Behaviors and Health Risk Assessment

Section 1.022H(6) Enrollee Services, the second paragraph is replaced in its entirety with the following:

Contractors must ensure that all HMP enrollees have an opportunity to complete a health risk assessment annually and receive the first health risk assessment upon initial enrollment with an MHP Contractor. Contractors must utilize the DCH-approved Health Risk Assessment (HRA) protocol. MI Enrolls will conduct the initial HRA for HMP enrollees via the telephone at the time of enrollment with the Contractor. The HRA results will be transmitted via a secure gateway to the Contractor.

4. Explanation of Benefits

Section 1.022(O)(2) Program Integrity final paragraph is hereby replaced in its entirety with the following:.

The Contractor is required to provide Explanation of Benefits (EOBs) to a minimum of 5% of the enrollees receiving services. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution during the compliance review process

5. Program Integrity

Section 1.022(O)(3) Reporting is hereby replaced in its entirety with the following:

At the time of suspicion, the Contractor must report/refer <u>all</u> (employee, providers and members) suspected of fraud or abuse to Office of Health Services Inspector General (OHSIG) via email (dch-oig@michigan.gov), online (michigan.gov/fraud), or through mail delivery to PO Box 30062, Lansing, MI 48909. The report/referral must include, at minimum:

- Subject (name, address, phone number, member Medicaid identification number, provider NPI and type, and any other identifying information)
- Source/origination of the complaint
- Date reported/referred to OHSIG
- Nature of the complaint including, but not limited to:
    - Type of service
    - Factual explanation of the suspected fraud/abuse
    - Medicaid statutes, rules, regulations, or policies violated
    - Dates of suspected fraud or abuse

- Approximate range of dollars involved
- Amount paid on behalf of a member or to a provider during the past three years or during the period of the suspected fraud or abuse, whichever is greater
- Encounter claims for the amount paid on behalf of a member or to a provider during the past 3 years or during the period of the suspected fraud or abuse, whichever is greater
- All communications between the Contractor and member or provider concerning the suspected fraud or abuse
- Contact information for Contractor staff person with the most knowledge relating to the report/referral
- Legal and administrative disposition of the case, <u>including actions taken by law enforcement officials to whom the case has been referred</u>
- Any and all documentation, data, or records obtained, reviewed, or relied on by the Contractor leading to the suspicion of fraud or abuse including but not limited to:
    - Beneficiary/Patient files
    - Audit reports and findings
    - Medical Necessity reviews and the reviewing personnel

Additionally, the Contractor must provide the numbers and details of program integrity activities performed quarterly. These activities fall into four categories – tips/grievances, data mining/algorithms, audits, and provider disenrollment's. Activities performed January through March must be reported by May 1; activities performed April through June must be reported by August 1; activities performed July through September must be reported by November 1; and activities performed October through December must be reported by February 1. Program integrity activities must be reported to OHSIG in the format developed by the State. A Contractor not initiating any data mining activities or performing any audits within a given quarter will receive a failing grade for that quarter's submissions.

The Contractor shall disclose to OHSIG the names and NPI numbers of providers being placed on prepayment review at the time the provider is placed on prepayment review status. The Contractor's shall include in such disclosure the following:

- The date of the prepayment review was initiated
- The reason for the prepayment review

The data or information relied on in placing the provider on prepayment review. The Contractor must inform OHSIG of actions taken to investigate or resolve the reported suspicion, knowledge, or action. The Contractor must also cooperate fully in any investigation by OHSIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

The Contractor is permitted to disclose protected health information to OHSIG without first obtaining authorization from the enrollee to disclose such information, and is required to make such disclosures upon OHSIG's request without requiring the service of process. The Contractor is also permitted to disclose protected health information to the Department of Attorney General without first obtaining authorization from the enrollee to disclose such information. OHSIG and the Department of Attorney General shall ensure that such disclosures meet the requirements for disclosure made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.50.

6. MIS Capability

Section 1.022P(2), the second sentence is hereby amended to include the following:

(g) Collecting enrollee income, group composition, and federal poverty level information for HMP enrollees

7. Performance Bonus
   Section 1.062(B) is hereby replaced in its entirety with the following:

   During each Contract year, DCH will withhold .0019 of the approved capitation payment from each Contractor. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

   DCH will establish a separate Targeted Performance Incentive Award. Funds allocated to this award will be distributed in equal proportions to each qualifying Contractor. DCH will establish the criteria used to distribute this award to Contractors. DCH will establish the percentage of the withhold funds to be allocated to the performance bonus template and the percentage to be allocated to the Targeted Performance Incentive Award. DCH will communicate the established percentages to the Contractor prior to the start of each fiscal year.

8. Payment Option
   Section 1.062C is hereby removed in its entirety.

9. Appendix 2
   Appendix 2 is hereby replaced in its entirety with the attached.

10. Appendix 3
    Appendix 3 is hereby replaced in its entirety with the attached.

11. Appendix 4
    Appendix 4 is hereby replaced in its entirety with the attached.

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

13. Attachment B Fiscal Year 2015
    Attachment B is hereby amended to include the following new section

    Update to Fiscal Year 2015

    Effective 1/1/2015, the Medicaid Health Plan rates will be modified in accordance with Section 1801 of PA 252 of 2014. This change will require the Medicaid Health Plans to continue a portion of the Primary Care Physician Incentive Payment Program which increases Medicaid rates for certain primary care services provided only by primary care providers.

    Fiscal Year 2015

    The State of Michigan Fiscal Year 2015 Managed Care Rates, effective October 1, 2014 through September 30, 2015, 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 2015 will be distributed under separate cover and are incorporated herein by reference.

Retroactive Contract Changes FY 2014
Contract Change is Effective 4/01/2014 and 07/01/2014 respectively

14. Attachment B Fiscal Year 2014
    Attachment B is hereby amended to include the following new section.

    Update to Fiscal Year 2014

    In accordance with amendment to PA 94 of 1937, the Medicaid Health Plan rates are retroactively increased to include reimbursement relative to a 5.98% tax on the use and consumption of medical services. The change is effective 4/1/2014.

    Additionally, the rates were modified effective 7/1/2014 in accordance with amendments to PA 142 of 2011 which reduced the Health Insurance Claims Assessment from 1.0% to .75%, retroactively effective 7/1/2014.

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:
    - On-going set appointment times for a one month period for standing appointments such as, but not limited to, dialysis, chemotherapy or physical therapy
    - Regularly scheduled appointments; plans may require reasonable advance notice (e.g. 48 – 72 hours) of the need for transportation
    - 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/Exemption s 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.	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, 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	

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***, <u>R/E breakout reports by specialty submitted to DCH by 8/15/2013 (Use the template provided)</u> -***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 <u>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.</u>	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.

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

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.	David Livingston, President	dlivingston@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, 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.

Per agency and vendor agreement and DTMB Procurement approval.

Contract Changes for Fiscal Year 2013
Contract Changes are Effective 10/01/2012

Section A: CSHCS Eligibility and Enrollment

1. Revise Section 1.022 (B) (2) CSHCS Eligibility and Enrollment to read as follows:

The Contractor must follow DCH procedures for the determination and re-determination of CSHCS medical eligibility. DCH reserves the right to require additional information from the Contractor to determine the enrollee's eligibility for CSHCS. The effective date of enrollment in the CSHCS-MC benefit plan is either (1) the first of the month of the child's admission to a facility during which the eligible condition was identified or (2) if the child was not admitted to a facility when the eligible condition was identified, the first of the month that eligible condition was identified and services for the condition were provided.

The Contractor or hospital must submit a complete Medical Eligibility Referral Form (MERF) containing all necessary signatures and ***all*** information required by DCH to determine medical eligibility to DCH within 30 calendar days of admission or Contractor's receipt of notification of the eligible condition. If complete medical documentation that meets the guidelines specified by DCH is not available within the 30-day timeframe, the health plan must submit the MERF and all required medical documentation within 10 calendar days after the information becomes available. The Contractor must notify the enrollee when submitting the MERF to DCH.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

2. Revise Section 1.022 (F) to add new section (21) **Special Coverage Provisions** to read as follows:

(21)CSHCS Enrollees

Special conditions apply to enrollees in the Contractor's health plan who are enrolled in CSHCS. The Contractor should allow CSHCS enrollees to remain with primary and specialty care providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established primary and specialty care providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees; if the primary and 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. CSHCS enrollees may be brought into network through transition to an appropriate network provider upon consultation and arrangement with the family and the care team. Additionally, if a non-contracted 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 CSHCS 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 and medical supplies, Contractors must accept prior authorizations in place when the CSHCS enrollee is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractors must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization. Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services.

Additionally, Contractors must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. 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.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

3. Revise Section 1.022 (F)(7) to include CSHCS specific carved-out drugs to the list of medications for which the MHPs are not responsible. Specifically, revise 1.022 (F)(7) to read as follows:

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

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

(a) Pharmacy Carve Out
The Contractor is not responsible for drugs in the categories listed on the Medicaid Health Plan carve out list found at https://michigan.fhsc.com/Providers/DrugInfo.asp. The carve out list includes drugs in the following categories:

- anti-psychotic classes and the psychotropic
- drugs in the anti-retroviral classes, including protease inhibitors and reverse transcriptase inhibitors
- substance abuse treatment drugs ; and
- drugs to treat coagulopathies such as hemophilia and orphan drugs which treat rare metabolic conditions

These medications are reimbursed by DCH's pharmacy third party administrator (TPA) through a point-of-service reimbursement system.

The Contractor is still responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for enrollees but may limit access to contracted lab and x-ray providers.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

4. Revise Section 1.022 (H)(2) by adding the following language at the end of the current section:

The Contractor is encouraged to provide specially targeted outreach and education to CSHCS enrollees. The Contractor should provide specific information to CSHCS on navigating the managed care system as well as detailed information on Contractor member services available to assist the enrollee. The Contractor must designate special member services staff to assist CSHCS enrollees and provide these member services staff with additional training and education needed to accommodate the special needs of CSHCS enrollees. CSHCS enrollees and family should be able to access the specially trained member services staff directly.

The Contractor must establish and maintain education and outreach on the Contractor's web site specifically directed to CSHCS enrollees. CSHCS enrollees and families should be able to utilize the web site to obtain information relevant to the special needs of these enrollees. The web site should also allow a mechanism for CSHCS enrollees and family to contact specially trained staff to assist them with access to services and CSHCS enrollee-specific questions.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

5. Revise Section 1.022 (I)(2)(d) to read as follows:

(2)Grievance and Appeal Procedure Requirements

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

. . .

(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. In reviewing appeals for CSHCS enrollees, the Contractor should utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate or limit pediatric subspecialist provider services.

6. Also, revise Section 1.022(P)(1)(e) to read as follows:

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:

. . .

(e) 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

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

7. Revise first paragraph of 1.022(R) to read as follows:

The Contractor must maintain a network of qualified providers in sufficient numbers and locations within the counties in the service area, including counties contiguous to the Contractor's service area, to provide required access to covered services. The Contractors network must include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees. The Contractor must also provide or arrange accessible care 24 hours per day, 7 days per week to the enrolled population. The Contractor is solely responsible for arranging and administering covered services to enrollees. Covered services must be medically necessary and administered, or arranged for, by a designated PCP. The Contractor must demonstrate that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of all enrollees within each enrollment area. The delivery system (in- and out-of-network) must include sufficient numbers of providers with the training, experience, and specialization to furnish the covered services listed in **Sections 1.022(E) and 1.022(F)** of this Contract to all enrollees.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

8. Revise the second paragraph of Section 1.022(R)(1), the third paragraph of Section 1.022(S)(1) and Section 1.022(S)(3) add a new Section 1.022(S)(4) to read, respectively, as follows:

Enrollees must be provided with an opportunity to select their PCP. CSHCS enrollees must be allowed to remain with the PCP with whom these enrollees have an established relationship at the time of enrollment in the health plan. Contractors are encouraged to seek contracts with PCPs with established relationships with CSHCS enrollees. CSHCS enrollees may be transitioned to an in-network PCP upon consultation with the family and the care team.

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

(1)PCP Choice

The Contractor must allow a physician specialist to serve as a PCP when the enrollee's medical condition warrants management by a physician specialist. This may be necessary for those enrollees with conditions such as diabetes, end-stage renal disease, HIV/AIDS, or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the enrollee. If the enrollee disagrees with the Contractor's decision, the enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file a Fair Hearing Request with DCH. Prior to assigning a specialist as PCP for a CSHCS enrollee, the Contractor must ensure that the specialist's office can adequately provide all necessary primary care services.

(3)PCP Availability

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

The Contractor must allow a CSHCS enrollee to choose a network PCP that is more than 30 minutes, 30 miles from the enrollee's residence under either or both of the following conditions:

- The CSHCS enrollee has an established relationship with the PCP at the time of enrollment in the health plan
- Upon consultation with the family, the selected PCP is the most appropriate PCP for the CSHCS enrollee

If either or both of the above conditions are met, Contractors must provide transportation to PCP services more than 30 minutes, 30 miles from the enrollee's residence. If neither of the above conditions is met and the enrollee still chooses a PCP that is more than 30 minutes or 30 miles from the enrollee's residence, the Contractor is not responsible for transportation to PCP services.

(4)CSHCS PCP Requirements

Contractors must maintain a roster of PCP providers that may appropriately serve CSHCS enrollees. Contractors should consider the following criteria when designating a PCP as appropriate to serve CSHCS enrollees:

- The PCP should regularly serve children or youth with complex chronic health conditions
- The PCP practice should have a mechanism to identify children/youth with chronic health conditions
- The PCP practice should provide expanded appointments when the child/youth has complex needs and requires more time
- The PCP practice should have experience coordinating care for children/youth who see multiple professionals (pediatric subspecialists, physical therapists, mental health professionals, etc.)
- The PCP practice should have a designated professional responsible for care coordination for children/youth who see multiple professionals

- The PCP practice should indicate willingness to accept new patients (children/youth) with complex chronic health conditions
- The PCP should whenever possible, be appropriate for youth and adults who are transitioning to adulthood

Contractors must obtain a written attestation from PCP providers who are qualified and willing to serve CSHCS enrollees. The attestation must specify that the PCP meets the qualifications stated in the above bulleted list.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

9. Add the following language to the end of the new Section 1.022(S)(4) to read as follows:

Contractors are encouraged to assign CSHCS enrollees to PCP practices that provide family-centered care and family-centered medical homes. Contractors are encouraged to place CSHCS enrollees with PCP practices that utilize the American Academy of Pediatric core principles of patient- and family-centered care.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

10. Revise Section 1.022(W)(1) to read as follows:

(a) Local Organizations and Providers

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

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

It is also beneficial for the Contractor to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, CAHCPs and FQHCs are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

The Contractor must establish and maintain agreements with all Local Health Departments for CSHCS enrollees in the Contractor's service area to coordinate care. Local Health Departments and the Contractor may share enrollee information to facilitate coordination of care without specific authorization from the enrollee. The enrollee has given consent to share information for purposes of payment, treatment and operations as part of the Medicaid Beneficiary Application.

The agreement must address all of the following topics:

- Data sharing
- Communication on development of Care Coordination Plan
- Reporting requirements
- Quality assurance coordination

- Grievance and appeal resolution
- Dispute resolution
- Transition planning for youth

The Contractor will not be responsible for care coordination services provided by the LHD. The Department of Community Health will continue to provide payment to LHDs for care coordination services. However, both the Contractor and the LHD are mandated to communicate to ensure that a cohesive Care Coordination Plan is established for each CSHCS enrollee

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

11. Revise contract section 1.022(F) by adding the following as a new Section 1.022(F)(22), titled Durable Medical Equipment and Medical Supplies:

Contractors must operate consistently with all applicable Medicaid coverage and limitation policies including Medicaid guidelines for medical necessity of Durable Medical Equipment and Medical Supplies. Contractors must provide the full range of covered services listed in the contract and Contractors may also choose to provide services over and above those specified. However, Contractors are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements in accordance with 1.022(F)(21).Role of Children's Multidisciplinary (CMS) clinics

Proposed contract changes: Revise section 1.022(W), Coordination of Care with Public and Community Providers and Organizations, to add a new section which reads as follows:

The Contractor must establish and maintain a coordination agreement with each CMS clinic facility to ensure coordinated care planning and data sharing, including but not limited to, the assessment, treatment plan and care coordination. Transportation to Children's Multidisciplinary Specialty (CMS) clinics is part of the covered transportation benefit and, as such, must be provided by the Contractor.

DCH is responsible for payment of special facility fees to the CMS clinics; the Contractor is not required to cover these special fees to CMS clinics. However, all covered services provided at the CMS clinic are the responsibility of the Contractor.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

12. Revise contract section 1.022(Y), Payment to contracted providers, to add the requirement that MHPs make a monthly payment to Family Centered Medical Home providers for each CSHCS enrollee. Specifically, add a new subsection 1.022(Y)(8) at the end of the current 1.022(Y) that reads as follows:

Contractors must make special payments to the contracted primary care providers who serve CSHCS enrollees. Specifically, the Contractor must make the following per member per month payments:

- $4 to each primary care provider serving a TANF CSHCS enrollee
- $8 to each primary care provider serving an ABAD CSHCS enrollee

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

13. Modify the first paragraph of 1.022(AA)(2) to read as follows:

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. For prior authorization decisions related to CSHCS enrollees the Contractors are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals and ancillary providers available and appropriate to render services to CSHCS enrollees. The Contractor is also encouraged to utilize Office of Medical Affairs Medical Consultants for assistance in determining appropriate durable medical equipment for CSHCS enrollees.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

14. Revise contract section 1.031 by adding the following as a new Section 1.031(D):

The Contractor must establish and maintain a written procedure and process to obtain information from CSHCS enrollees and families. CSHCS enrollees and families must be given the opportunity to provide input on Contractor policies and/or procedures that influence access to medical services or member services and information. Contractors are encouraged to develop forums for discussion between the CSHCS enrollees and families and the Contractor.

Rationale: Contract change is needed to implement enrollment of dual Title V and Title IX beneficiaries into the Medicaid Health Plans

Section B: Changes for FY13 Due to Policy and Procedure Changes

1. Modify Section 1.022(E) to include re-instated Chiropractic and Vision Service

   - Chiropractic services

Rationale: Legislature re-instated the funding for Chiropractic and Vision services for Medicaid beneficiaries

2. Revise section 1.022(F)(5) to remove the reference to open enrollment.

The Contractor may require co-payments by enrollees, consistent with State and federal guidelines, Medicaid Policy, waivers obtained by DCH, and other DCH requirements. 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.

Rationale: Michigan has moved to rolling open enrollment; therefore co-payment changes may not be tied to an annual open enrollment period.

3. Revise contract 1.022(A) to include beneficiaries who are authorized to receive private duty nursing services among the excluded populations for purposes of MHP enrollment. Specifically, add a bullet under the subtitle "Medicaid Eligible Groups Excluded from Enrollment in the CHCP" in 1.022(A) that reads as follows:

- Persons authorized to receive private duty nursing benefits

Rationale: Most individuals receiving private duty nursing benefits are dual Title V and Title XIX beneficiaries. Individuals with private duty nursing services become an excluded population upon the enrollment of dual Title V/Title XIX individuals into Medicaid Health Plans due to the need to maintain consistency with the regular MHP services package logic

4. Modification Section 1.22(O)(2) to update the review site from Excluded Parties List System (EPLS) to System for Award Management(SAM)

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 System for Award Management (SAM) at www.sam.gov, 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 SAM 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: Needed to align with the change by CMS from EPLS to SAM

5. Modification for Fraud and Abuse Contact Information

A Contractor who has any suspicion or knowledge of fraud and/or abuse within any of DCH's programs must report directly to Office of Health Services Inspector General by calling (855) 643- 7283, online at www.michigan.gov/fraud, or in writing to:

Office of Health Services Inspector General
PO Box 30479

The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the enrollees receiving services. The EOB distribution must comply with all State and federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution during the compliance review process.

(1) Reporting of Fraud and Abuse
The Contractor must report all (employee, providers and members) suspected fraud and/or abuse that warrant investigation to Office of Health Services Inspector General.

Additionally, the Contractor must provide the number of complaints warranting a preliminary investigation since the previous compliance review visit. Further, for each complaint warranting full investigation, the Contractor must provide to OHSIG Medicaid Integrity Program the following information:

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

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

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

Rationale: Department of Community Health Medicaid Program Integrity Unit moved to the Office of Health Services Inspector General.

6. Updated Appendix 3, 4, and 5 attached

Appendix 3

2013 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	3/1/13	1/1/12 – 12/31/12	Contract 1.042A(2)
• Health Plan Profile (MSA 126 (01/06)) NOTE: **Follow instructions carefully and include all required attachments.** • 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	4/1/13	1/1/12 – 12/31/12	Contract 1.042 A(2)
Audited Financial Statements	6/1/13	1/1/12 – 12/31/12	NAIC, OFIR
QIP Annual Evaluation and Work Plan	8/1/13	Current, Approved 2012 Evaluation, 2013 Work Plan	Electronic Format; Contract 1.022 Z(1-4)
HEDIS® Compliance Audit – Final Audit Report	8/1/13	1/1/12 – 12/31/12	NCQA formatted, electronic copy
HEDIS® IDSS	7/1/13	1/1/12 – 12/31/12	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" lette			
Quarterly Submissions			
Grievance/Appeal	1/30/13 4/30/13 7/30/13 10/30/13	10/1/12 – 12/31/12 1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	MSA 131 (11/11), Grievance & Appeal Log

Report Reference	Due Date	Period Covered	Instructions/Format
Financial	5/15/13 8/15/13 11/15/13	1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	NAIC and OFIR
Third Party Collection	5/15/13 8/15/13 11/15/13	1/1/13 – 3/31/13 4/1/13 – 6/30/13 7/1/13 – 9/30/13	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 2/13 due by 3/30/13	MSA 2009 (E)
Encounter Data	The 15th of each Month	• Minimum of Monthly • Data covers previous month • i.e., data for 1/13 due by 2/15/13	837 Format NCPDP Format
Provider Files (4275)	Friday 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
(Contract Year October 1, 2012 – September 30, 2013)

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.	Combination 3 ≥73%	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	≥89%	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.	≥72%	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	HEDIS report	Annual
• **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	≥68%	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 or more well child visits during twelve-month period.	≥73%	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 ≤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

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