

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. 10**  
 to  
**CONTRACT NO. 071B0200019**  
 between  
**THE STATE OF MICHIGAN**  
 and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
PHP FamilyCare 1400 E. Michigan Avenue Lansing, MI 48912	Scott Wilkerson	<a href="mailto:scott.wilkerson@phpmm.org">scott.wilkerson@phpmm.org</a>
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(517) 364-8300	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Greg Rivet	(517) 335-5096	<a href="mailto:rivetg@michigan.gov">rivetg@michigan.gov</a>
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	<a href="mailto:kingsburyl@michigan.gov">kingsburyl@michigan.gov</a>

CONTRACT SUMMARY:			
DESCRIPTION: Comprehensive Health Care Program – Department of Community Health (Clinton, Eaton, Ingham, Ionia, Isabella, Shiawassee)			
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, 2014
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
<input type="checkbox"/> P-card <input type="checkbox"/> Direct Voucher (DV) <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>		Sept. 30, 2014
VALUE/COST OF CHANGE NOTICE:		ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:		
\$0.00		\$329,785,406.29		
Effective October 1, 2014, 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:

- Intensive tobacco use treatment through a DCH approved telephone quit line
- Group and/or individual counseling/coaching for tobacco cessation treatment separate from the 20 outpatient mental health visits
- All of the following Over-the counter agents used to promote smoking cessation
  - Patch
  - Inhaler
  - Nasal Spray
  - Gum or lozenge
- At least one prescription of non-nicotine medication used to promote smoking cessation
- 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:

- Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by DCH through an encounter data system
- 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
- 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<sup>®</sup>) 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%		NCOA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
<i>Clinical Measures - 2014 HEDIS</i>	2014 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
<b>Women's Care</b>					
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%
<b>Living with Illness</b>					
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%
<b>Pediatric Care</b>					
<b>Well Child Visits</b>					
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%
<b>Other</b>					
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%
<i>Access to Care - 2014 HEDIS</i>	2014 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
<b>Children</b>					
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%
<b>Adult</b>					
20-44 Years		0	0.0%	0.0%	0.0%
45-64 Years		0	0.0%	0.0%	0.0%
<i>Survey Measures - CAHPS</i>	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%
<i>Smoking Measures</i>	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%
<b>Accreditation Status - 2014</b>		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		
<i>Clinical Measures (54.84%)</i>		68	0.0		
<i>Access to Care (19.35%)</i>		24	0.0		
<i>Survey Measures (CAHPS) (17.74%)</i>		22	0.0		
<i>Accreditation Status (8.06%)</i>		10	0.0		
			CAHPS Survey Measures based on 2013 NCQA Quality Compass Medicaid Percentiles		
<b>Performance Bonus Total Score</b>		124	0.0		

**Appendix 2**

**DCH Financial Monitoring Standards**

<b>Reporting Period</b>	<b>Monitoring Indicator</b>	<b>Threshold</b>	<b>DCH Action</b>	<b>Health Plan Action</b>
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
<b>Annual Submissions</b>			
<b>Consolidated Annual Report</b>	3/1/14	1/1/13 – 12/31/13	Contract 1.042A(2)
<ul style="list-style-type: none"> <li>• Health Plan Profile (MSA 126 (01/06)) NOTE: <b>Follow instructions carefully and include all required attachments.</b></li> <li>• Financial (NAIC, all reports required by OFIR, and Statement of Actuarial Opinion are due with the annual report on 3/1/14). NOTE: <i>The Management Discussion and Analysis is due 4/1/14 and the Audited Financial Statements are due 6/1/14.</i></li> <li>• Health Plan Data Certification Form (MSA 2012 (02/08)).</li> <li>• Litigation (limited to litigation directly naming health plan, MSA 129 (09/99))</li> <li>• Physician Incentive Program (PIP) Reporting (DCH PIP Attestation form and PIP Disclosure forms)</li> <li>• Medicaid Certificate of Coverage</li> <li>• Medicaid Member Handbook</li> <li>• EPSDT Requirements: <ul style="list-style-type: none"> <li>○ <b>Incentives:</b> 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</li> </ul> </li> </ul>			
<b>Management Discussion and Analysis for Annual Financial</b>	4/1/14	1/1/13 – 12/31/13	Contract 1.042 A(2)
<b>Audited Financial Statements</b>	6/1/14	1/1/13 – 12/31/13	NAIC, OFIR
<b>QIP Annual Evaluation and Work Plan</b>	8/1/14	Current, Approved 2013 Evaluation, 2014 Work Plan	Electronic Format; Contract 1.022 Z(1-4)
<b>HEDIS® Compliance Audit – Final Audit Report</b>	8/1/14	1/1/13 – 12/31/13	NCQA formatted, electronic copy
<b>HEDIS® IDSS</b>	7/1/14	1/1/13 – 12/31/13	NCQA formatted, electronic copy
<ul style="list-style-type: none"> <li>• Auditor-locked Excel format Audit Review Table (ART)</li> <li>• Excel Downloads: Comma Separated Values (CSV) Workbook</li> <li>• Excel Downloads: Data-filled Workbook (measure level detail file), and</li> <li>• Copy of MHP’s signed and dated “Attestation of Accuracy and Public Reporting Authorization-Medicaid” letter</li> </ul>			
<b>Quarterly Submissions</b>			
<b>Grievance/Appeal</b>	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

Report Reference	Due Date	Period Covered	Instructions/Format
<b>Financial</b>	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
<b>Third Party Collection</b>	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
<b>Monthly Submissions</b>			
<b>Claims Processing</b>	30 days after end of the month NOT last day of month	<ul style="list-style-type: none"> <li>• Data covers previous month</li> <li>• i.e., data for 2/14 due by 3/30/14</li> </ul>	MSA 2009 (E)
<b>Encounter Data</b>	The 15 <sup>th</sup> of each Month	<ul style="list-style-type: none"> <li>• Minimum of Monthly</li> <li>• Data covers previous month</li> <li>• i.e., data for 1/14 due by 2/15/14</li> </ul>	837 Format NCPDP Format
<b>Provider Files (4275)</b>	Thursday before the last Saturday of each month	<ul style="list-style-type: none"> <li>• Submit all providers contracted with the plan on the date of submission</li> <li>• Submit two files, one utilizing the MA-MC provider voluntary ID and one utilizing the CSHCS-MC provider voluntary ID</li> </ul>	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
<p><b>Benefits Monitoring Program (BMP) Innovation</b></p> <p><b>1. Placement of candidates</b></p> <p><b>2. Criteria for PCP assignment and provider lock-in</b></p> <p><b>3. Care management models</b></p>	<p>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)</p> <p>1. The placement of a beneficiary into the BMP (a monitoring program) must be based on one or more defined criteria; such as:</p> <ul style="list-style-type: none"> <li>a. Fraud</li> <li>b. Misutilization of ER, Rx, transportation or physician services</li> <li>c. other</li> </ul> <p>2. The BMP authorized providers assigned may include a specific PCP, pharmacy, outpatient hospital, specialist or group practice.</p> <p>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.</p> <p>3. MHPs must work with the assigned providers to collaborate on case management, coordination of all prescribed drugs, specialty care and ancillary services.</p>	<p>The MHP must provide information that describe and support efforts to conduct surveillance and benefits utilization review.</p> <p>1. <b>Due October 1, 2013</b> – MHP will have a <i>DCH approved</i> Policy/Procedures that describe its Monitoring Program and coordination with the DCH BMP policy. <b>(MHPs must submit their draft P/P for DCH approval by 7/1/2013).</b></p> <ul style="list-style-type: none"> <li>a. Placement criteria</li> <li>b. Restrictions/Exemptions</li> <li>c. Notice/communication to member</li> <li>d. Hearings/Appeals</li> <li>e. Monitoring and Review</li> </ul> <p>2. <b>Due April 1, 2014</b> – MHP provide:</p> <ul style="list-style-type: none"> <li>a. Criteria for PCP assignment</li> <li>b. Mechanism of provider lock-in</li> <li>c. Provider referral process</li> <li>d. Notice of discharge of member</li> </ul> <p>3. <b>Due July 1, 2014</b> – MHP to: Develop and/or incorporate BMP members into existing care management model specific to this population</p>

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. 071B0200019**  
 between  
**THE STATE OF MICHIGAN**  
 and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
PHP FamilyCare 1400 E. Michigan Avenue Lansing, MI 48912	Scott Wilkerson	<a href="mailto:scott.wilkerson@phpmm.org">scott.wilkerson@phpmm.org</a>
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(517) 364-8300	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Greg Rivet	(517) 335-5096	<a href="mailto:rivetg@michigan.gov">rivetg@michigan.gov</a>
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	<a href="mailto:kingsburyl@michigan.gov">kingsburyl@michigan.gov</a>

CONTRACT SUMMARY:			
DESCRIPTION: Comprehensive Health Care Program – Department of Community Health (Clinton, Eaton, Ingham, Ionia, Isabella, Shiawassee)			
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, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
<input type="checkbox"/> P-card <input type="checkbox"/> Direct Voucher (DV) <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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
<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 year	Sept. 30, 2014
VALUE/COST OF CHANGE NOTICE:		ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:		
\$88,927,133.00		\$329,785,406.29		

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 \$88,927,133.00. 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**

1. 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

2. 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/EPSTDT examination. The required Well Child/EPSTDT 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.

3. 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.

4. 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

5. 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.

6. ACA Primary Rate Increase

Section 1.022(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.

7. 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.

8. Revised Appendix 5

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

9. 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  
2013 CSHCS Focus Study**

Competency	Area of Focus	Points Possible	Points Awarded
1	<b>Access to Care</b> – Evidence of access standards for CSHCS population and processes to evaluate compliance with those standards	5	
2	<b>Access to Care</b> – 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	<b>Access to Care</b> – Review executed contracts or effort to network with pediatric subspecialist, children’s hospitals, pediatric specialty care hospitals and pediatric regional centers	5	
4	<b>Access to Care</b> – Evidence of implemented PA process with pediatric subspecialists	5	
5	<b>Access to Care</b> – Evidence of implemented PA process with specialty DME	5	
6	<p><b>IT Systems</b> – Generate measures of utilization, access and quality of care, demonstrate tracking ability, and review data sharing activities</p> <p><b>Quality of Care</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</p> <p>Evidence of established clinical practice guidelines specific to CSHCS, such as, diabetes (type 1), asthma and sickle cell disease, etc.</p>	5	
7	<b>Member Rights (Grievance &amp; Appeals)</b> – 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	<b>Family Centered Medical Home</b> – 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**

Health Plan Name	FY 13 Performance Bonus Template		NCQA Medicaid Percentiles (please note, previous years percentiles will be entered when they become available.)		
<i>Clinical Measures - 2013 HEDIS</i>	2012 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
<b><i>Women's Care</i></b>					
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%
<b><i>Living with Illness</i></b>					
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%
<b><i>Pediatric Care</i></b>					
<b>Well Child Visits</b>					
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%
<b>Other</b>					
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%
<i>Access to Care - 2013 HEDIS</i>	2013 HEDIS Score	50% (1 point); 75% (2 points); 90% (4 points)	50%	75%	90%
<b>Children</b>					
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%
<b>Adult</b>					
20-44 Years	0		0.0%	0.0%	0.0%
45-64 Years	0		0.0%	0.0%	0.0%
<i>Survey Measures - CAHPS</i>	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%

<b>Smoking Measures</b>	<b>Score</b>	<b>50% (1 point); 75% (2 points); 90% (3 points)</b>	<b>50%</b>	<b>75%</b>	<b>90%</b>
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Tobacco Cessation Strategies 0 0.0% 0.0% 0.0%

Medical Assistance with Smoking and Tobacco use 0 0.0% 0.0% 0.0%

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

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

Point Summary	Possible Points	Health Plan Points	DCH Focus (Total 40 Pt.)	Score	Incentive Points
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<i>Clinical Measures (42.0%)</i>	68	0.0	CSHCS	0.0%	0.0
<i>Access to Care (15.0%)</i>	24	0.0			
<i>Survey Measures (CAHPS) (13.0%)</i>	22	0.0	Total Points		
<i>Accreditation Status (6.0%)</i>	10	0.0	CAHPS Survey Measures		
<i>Focus Study Requirements (24.0%)</i>	40	0.0			

<b>Performance Bonus Total Score</b>	<b>164</b>	<b>0.0</b>	<b>** based on 2012 NCQA Quality Compass Medicaid Percentiles.</b>		
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**Appendix 5**  
**2013 DCH P4P Bonus**  
**Healthcare for a Diverse Membership**

Category	Description	Criteria/Deliverables
<p>1. Race/Ethnicity and preferred language data collection reporting</p> <p>2. Provider Network</p> <p>3. Health Equity</p>	<p>1. MHP fully and accurately reports the following on the HEDIS IDSS:</p> <p style="margin-left: 20px;">a. Race/Ethnicity Diversity of Membership (RDM)</p> <p style="margin-left: 20px;">b. Language Diversity of Membership (LDM)</p> <p>2. MHP collects and reports on race/ethnicity/language (R/E/L) proficiency for network providers.</p> <p style="margin-left: 20px;">a. MHP publishes practitioner language information in the provider directory for all Primary Care Providers and Specialists (reference: 42CFR438(10)e(2)(i))</p> <p style="margin-left: 20px;">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)</p> <p style="margin-left: 20px;">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></p> <p>3. MHP submits HEDIS data broken down by R/E to DCH for specified measures</p>	<p>1. Complete an accurate IDSS for the appropriate measures submitted by 7/01/2013</p> <p>2. <b><i>-If the MHP currently does this, R/E breakout reports by specialty submitted to DCH by 8/15/2013 (Use the template provided)</i></b>  <b><i>-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)</i></b></p> <p style="margin-left: 20px;">a. Submit a copy of provider directory to DCH along with the Consolidated Annual Report by 3/1/2013</p> <p style="margin-left: 20px;">b. Submit documentation that such notification was provided. (e.g. copy of a letter, screenshot from online newsletter)</p> <p style="margin-left: 20px;">c. Submit report to DCH by 8/15/2013</p> <p>3. Submit completed templates to DCH 8/15/2013</p>

**Appendix 5**  
**2013 Bonus Measures Template**  
**DCH Focus - CSHCS**

Category	Description	Criteria/Deliverables
<p><b>Integration of Children’s Special Healthcare Services (CSHCS) eligible into MHPs</b></p> <p><b>40 points</b></p>	<p>MDCH established a set of core competencies to determine health plan readiness and competence to receive CSHCS eligible children into their plan.</p> <p>MHPs provided documentation regarding plans to accommodate this population.</p> <p>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.</p>	<p>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:</p> <ol style="list-style-type: none"> <li>1. Access to Care (related competencies #1, 2, 3, 4, 5, and 9)</li> <li>2. IT Systems (related competencies #1, 2, 5, 6, 7 and 9)</li> <li>3. Member Rights (related competencies #4, 5, 7, 8 and 9)</li> <li>4. Family Centered Medical Home (related competencies #2, and 8)</li> <li>5. Quality of Care (related competencies #6, 8, and 9)</li> </ol> <ul style="list-style-type: none"> <li>• DCH will obtain this information through the FY13 compliance review Focus Study.</li> <li>• Proposed timeframe for this review process will occur between March and <b>June</b> of 2013.</li> </ul>