

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET December 6, 2011
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
 OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (508) 562-2655 Donna M. Mellen
Magellan Medicaid Administration 4300 Cox Road Glen Allen, VA 23060		
dmmellen@magellanhealth.com		BUYER/CA (517) 241-3768 Lance Kingsbury
Contract Compliance Inspector: Laura Dotson (517.241.4686) Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH		
CONTRACT PERIOD:		From: April 1, 2010 To: March 31, 2013
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		
MISCELLANEOUS INFORMATION:		

NATURE OF CHANGE(S):

Effective immediately, this contract is hereby INCREASED by \$528,460.00 and the attached Statements of Understanding are hereby incorporated. Article 2 of this Contract is amended to include the following provision:

The Contractor agrees to comply with all disclosure regulations as defined in Federal Regulation 42 C.F.R. § 455.104, detailed below:

Disclosure by providers and fiscal agents: Information on ownership and control.

- (a) *Information that must be disclosed.* The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:
- (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any Subcontractor in which the disclosing entity has direct or indirect ownership of five percent or more;
 - (2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.
 - (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
 - (i) Keep copies of all these requests and the responses to them;
 - (ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) *Time and manner of disclosure.* (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.

(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) *Provider agreements and fiscal agent contracts.* A Medicaid agency must not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) *Denial of federal financial participation (FFP).* FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

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

AUTHORITY/REASON:

Per agency request, Ad Board approval on 1/17/2012, and DTMB Procurement.

INCREASE: \$528,460.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$21,290,080.00

**Statement of Understanding (SOU)
for Extract Changes
State of Michigan**

April 9, 2009

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule¹ provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

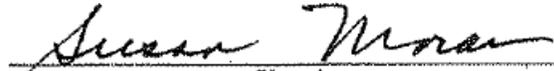
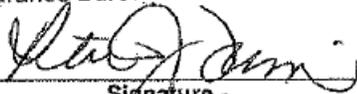
¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

First Health Services will deliver the requested change outlined in this Statement of Understanding by June 13, 2009, if Client signature approval is received by April 30, 2009.

 Signature	<u>Susan Moran</u> Printed Name
Director, Medicaid Program Operations and Quality Assurance Bureau Title	<u>6-15-09</u> Date
 Signature	<u>Peter J. Quinri</u> Printed Name
<u>Chief Operating Officer</u> Title	<u>7-9-09</u> Date
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview

The Michigan Department of Community Health is requesting additional information added to the current weekly paid claims extract.

2.0 Requirements

Claim Extract (4694): Adding the ICN number to claims extract:

- Populate new ICN number in filler space on current extract (positions 4-20).
- Reversal ICN info in filler space on current extract (positions 139-155).
- ICN information should also be added to compound extract.

Claim Extract (4694): Adding additional fields.

- Add additional information in filler space on current extract (position 544-645).
- Additional Data:
 - Transaction Code
 - Claim Type
 - Claim Status
 - Adjudicated Group ID
 - Pharmacy Panel ID

3.0 Assumptions

- All other data elements within the extract remain the same.
- First Health Services assumes that historical claims before implementation will be referred back using the old ICN numbers in voids after implementation.
- Since the FirstRX database is a transactional database the status of the claim may change relative to the date and time of the extract is performed. The status of a claim at the time of the extract will be reported in the claim status field.
- The level of effort is an estimate and the actual cost may have variation of up to 20%.

4.0 Constraints

- Limitations within the layout may require additional length at the end of the layout.
- First Health Services will map the new fields to data elements in FirstRX database. The values will be populated in the extract as long as it is available in the source database.

5.0 Issues and Concerns

- Claim Extract (4694): Adding additional fields (denied claims)
- Add additional information in filler space on current extract (position 544-645).
- Additional Data
 - Transaction Code
 - Claim Type
 - Claim Status

6.0 Scope of Work

- Prepare technical specifications and requirements including the new layout and mapping to the FirstRX data base. The Technical Specifications and Requirements (TSR) document will be submitted to the state for approval by the state.
- Develop application script to incorporate the changes as defined in the approved TSR.
- Test and deploy the changes to production. (see section 7.0 for detailed test plan).
- Transmit weekly files using existing mechanisms and schedules.

7.0 Test Plan

- Unit Testing

- First Health Services software development team will do the unit testing. The results of the unit testing will be documented for internal use.
- System Testing.
 - First Health Services will perform system testing and will share the results with the state.
 - First Health Services will run three simulated cycles in our QC region,
 - The first cycle will be executed with the current application
 - The second cycle will be executed with the new application. The second cycle will have claims that were processed in the first cycle.
 - The Third cycle will be executed with the new application. The Third cycle will have claims that were processed in the first and second cycles.
- Test Cases.
 - Original claims – Test for change in ICN numbers.
 - Void claims – Test for ICN and original ICN for claims in first and second cycles. Voids for claims in the first cycle will refer to old ICN format and voids for claims in the second cycle will refer to the new ICN.
 - Validate values in the FirstRX database with the values in the second and third cycle for the following fields.
 - Transaction Code
 - Claim Type
 - Claim Status
 - Adjudicated Group ID
 - Pharmacy Panel ID

8.0 Operational Impact

- There should be minimal operational impact once changes are moved to production.

9.0 Estimates and Costing

Activities	ETL	Totals	Target Completion Date
Concept	10	10	
Planning	4	4	
Requirements	6	6	
Design	14	14	June 1, 2009*
Construction	16	16	June 4, 2009
Testing	24	24	June 9, 2009
Implementation	4	4	June 12, 2009
Post Implementation	2	2	June 13, 2009
Total Implementation	80	80	

* Design documentation updates.

Estimated Resource Costs			
Resource Type	Hours	Rate	Charges
ETL	80	\$110.00	\$8,800.00
Total Implementation	80		\$8,800.00

- **Implementation Fee**– The implementation fee for this project is \$8,800.00. The implementation cost will be billed as a one time charge.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY (90) DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF FIRST HEALTH SERVICES CORPORATION.



First Health
Services Corporation

A Coventry Health Care Company

Statement of Understanding (SOU)
for Provider File Extract Changes
State of Michigan

July 15, 2009

Confidential and Proprietary

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HIPAA Privacy Rules

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Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

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¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

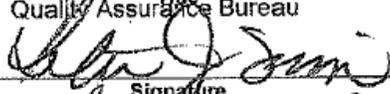
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Approvals Signature Page

First Health Services will deliver the requested change outlined in this Statement of Understanding by June 25, 2009, if Client signature approval is received by July 03, 2009.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

 Signature	Susan Moran Printed Name
Director, Medicaid Program Operations and Quality Assurance Bureau Title	July 30, 2009 Date
 Signature	Peter J. Quinn Printed Name
Chief Operating Officer Title	8-7-09 Date
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview

The Michigan Department of Community Health is requesting a new Provider File extract to be used with their new CHAMPS system.

2.0 Requirements

2.1 4702-Header-Record

2.1.1 Record Layout for CHAMPS

For each of the seven record types, the same format is used for the header and trailer records. Each header/footer record contains information about the type of record within the set and the count of records within the set.

Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	HD-EDI-HEADER-TYPE	X(04)	4		1	4	Yes	Yes	HDDR
2	HD-EDI-APPLICATION	X(02)	2		5	6	No	Yes	MA
3	HD-EDI-USER	X(04)	4		7	10	No	Yes	DCH0
4	HD-EDI-USER-ID	X(04)	4		11	14	No	Yes	16
5	HD-EDI-CREATION-DATE	X(08)	8	CCYYMMDD	15	22	Yes - valid calendar date	Yes	
6	HD-EDI-TRANSFER-DATE	X(08)	8	CCYYMMDD	23	30	Yes - valid calendar date	Yes	
7	HD-EDI-TRANSFER-TIME	X(04)	4	HHMM	31	34	Yes - valid time	Yes	

Record Format: 105415-001									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
8	HD-EDI-FILE-ID-BEGIN	X(04)	4		35	338	Yes	Yes	4702
9	HD-EDI-RUN-TYPE	X(01)	1		39	39	Yes	Yes	P - Production
T - Test									
10	HD-EDI-DAY-OF-WEEK	X(02)	2		40	41	No	Yes	ZEROS
11	HD-EDI-SEQUENCE	X(01)	1		42	42	No	Yes	1
12	FILLER	X(514)	514		43	556	No	No	Ignore all data within this element.

2.2 Layout of the Trailer Record

2.2.1 4702-Trailer Record

Record Format: 105415-001									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	TR-EDI-HEADER-TYPE	X(04)	4		1	4	Yes	Yes	TRLR
2	TR-EDI-APPLICATION	X(02)	2		5	6	No	Yes	MA
3	TR-EDI-USER	X(04)	4		7	10	No	Yes	DCH0

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Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
4	TR-EDI-USER-ID	X(04)	4		11	14	No	Yes	16
5	TR-EDI-CREATION-DATE	X(08)	8	CCYYMMDD	15	22	Yes - valid calendar date	Yes	
6	TR-EDI-TRANSFER-DATE	X(08)	8	CCYYMMDD	23	30	Yes - valid calendar date	Yes	
7	TR-EDI-TRANSFER-TIME	X(04)	4	HHMM	31	34	Yes - valid time	Yes	
8	TR-EDI-FILE-ID-BEGIN	X(04)	4		35	38	Yes	Yes	4702
9	TR-EDI-RUN-TYPE	X(01)	1		39	39	Yes	Yes	P - Production
T - Test									
10	TR-EDI-DAY-OF-WEEK	X(02)	2		40	41	No	Yes	ZEROS
11	TR-EDI-SEQUENCE	X(01)	1		42	42	No	Yes	1
12	TR-EDI-RECORD-COUNT	9(10)	10		43	52	Yes	Yes	Total number of records + 2
13	FILLER	X(504)	504		53	556	No	Yes	Ignore everything in this element

2.3 Layout of the Detail Record

Each Provider Information record is comprised of basic information about a pharmacy. In the header/footer records, the associated Record Type Identifier is '1'.

If a service provider is being terminated the Delete Date field is populated with non-zeros. All of its associated memberships and supporting information will also be terminated using the same Termination Date.

Each Medicaid Information record contains a state-specific Medicaid ID that is associated with a pharmacy. These records are sent as a master file. In the header/footer record, the associated Record Type Identifier is '6'. This data will not be loaded from the CHAMPS layout.

Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	PH-REC-CODE	X(03)	3		1	3	Yes	Yes	PGI
2	PH-PROV-TYPE	X(04)	4		4	7	Yes	Yes	A170 for Pharmacy Providers
3	PH-DBA-NAME	X(50)	50		8	57	No	Yes	Store as CHAMPS DBA Name
4	PH-LEGAL-ENTITY-NAME	X(50)	50		58	107	No	Yes	Pharmacy Name "As Licensed", cannot be blank Store as CHAMPS Legal Entity Name
5	PH-LIC-NUMBER	X(10)	10		108	117	Yes - for MI providers	Yes	State License Number
6	DEA NUMBER	X(9)	9		118	126	No	Yes	
7	PH-NATL-PROV-ID	X(10)	10		127	136	Yes	Yes	Pharmacy's NPI, validate with check digit
8	PH-FED-EMPLOYER-NO	X(09)	9		137	145	No	Yes	Store as CHAMPS Federal Tax ID Number

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Record Format: C-1031415									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
9	PH-NAIL-PHARM-NO	X(7)	7		146	152	Yes (format only)	Yes	NCPDP Number
10	PH-COUNTY-NAME	X(2)	2		153	154	Yes	No	Send two digit identifier for the appropriate MI county: 01 - Alcona 02 - Alger 03 - Allegan 04 - Alpena 05 - Antrim 06 - Arenac 07 - Baraga 08 - Barry 09 - Bay 10 - Benzie 11 - Berrien 12 - Branch 13 - Calhoun 14 - Cass 15 - Charlevoix 16 - Cheboygan 17 - Chippewa 18 - Clare 19 - Clinton 20 - Crawford 21 - Delta 22 - Dickinson 23 - Eaton 24 - Emmet 25 - Genesee 26 - Gladwin 27 - Gogebic 28 - Grand Traverse 29 - Greilof 30 - Hillsdale 31 - Houghton

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Record Format: rs03115									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
32	Huron								
33	Ingham								
34	Ionia								
35	Iosco								
36	Iron								
37	Isabella								
38	Jackson								
39	Kalamazoo								
40	Kalkaska								
41	Kent								
42	Keweenaw								
43	Lake								
44	Lapeer								
45	Leelanau								
46	Lenawee								
47	Livingston								
48	Luce								
49	MacKinac								
50	Macomb								
51	Manistee								
52	Marquette								
53	Mason								
54	Mecosta								
55	Menominee								
56	Midland								
57	Missaukee								
58	Monroe								
59	Montcalm								
60	Montmorency								
61	Muskegon								
62	Newaygo								
63	Oakland								
64	Oceana								
65	Ogemaw								
66	Ontonagon								
67	Oscoda								
68	Oscoda								

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Record Format to 03/15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									69 - Otsego 70 - Ottawa 71 - Presque Isle 72 - Roscommon 73 - Saginaw 74 - St Clair 75 - St Joseph 76 - Sanilac 77 - Schoolcraft 78 - Shiawassee 79 - Tuscola 80 - Van Buren 81 - Washtenaw 82 - Wayne 83 - Wexford 84 - Out of State - (Non-borderland) 85 - 86 - Ohio City 87 - Wisconsin City 88 - Indiana City 89 - Minnesota City Spaces to be sent by First Health until County Code is available
11	PH-ELIG-BEGIN- DT	X(08)	8	CCYYMM DD	155	162	Yes - valid calendar date	Yes	Only receive one occurrence of eligibility begin and end from First Health.
12	PH-ELIG-END- DT	X(08)	8	CCYYMM DD	163	170	Yes - valid calendar date	Yes	Only receive one occurrence of eligibility begin and end from First Health.
13	PH-ADDR-TYPE (S)	X(01)	1		171	171	Yes	Yes	30000101 = open-ended \$ (service address)

Records Format plus 16										
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition	
14	PH-ATTN-LINE (S)	X(30)	50		172	221	No	No	Store as CHAMPS PPL Address	
15	PH-STREET (S)	X(30)	30		222	251	No	Yes	Store as CHAMPS Address Line 2	
16	PH-PO-BOX (S)	X(05)	5		252	256	No	No	Store as CHAMPS Address Line 1	
17	PH-CITY (S)	X(30)	30		257	286	No	Yes	Store as CHAMPS Address Line 3	
18	PH-STATE (S)	X(02)	2		287	288	No	Yes		
19	PH-ZIP (S)	X(06)	6		289	293	No	Yes		
20	PH-ZIP-4 (S)	X(04)	4		294	297	No	No		
21	PH-TELE-NO (S)	X(10)	10		298	307	No	Yes		
22	PH-ADDR-TYPE (C)	X(01)	1		308	308	Yes	Yes	C (correspondence address)	
23	PH-ATTN-LINE (C)	X(50)	50		309	358	No	No	Store as CHAMPS Address Line 2	
24	PH-STREET (C)	X(30)	30		359	388	No	Yes	Store as CHAMPS Address Line 1	
25	PH-PO-BOX (C)	X(05)	5		389	393	No	No	Store as CHAMPS Address Line 3	
26	PH-CITY (C)	X(30)	30		394	423	No	Yes		

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Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
27	PH-STATE (C)	X(02)	2		424	425	No	Yes	
28	PH-ZIP (C)	X(06)	6		426	430	No	Yes	
29	PH-ZIP-4 (C)	X(04)	4		431	434	No	No	
30	INDEPENDENT PANEL INDICATOR	X(1)	1		435	435	Yes	Yes	Independent Panel Y = Yes, N = No
31	CHAIN PANEL INDICATOR	X(1)	1		436	436	Yes	Yes	Chain Panel Y = Yes, N = No
32	IV INFUSION PANEL INDICATOR	X(1)	1		437	437	Yes	No	IV Infusion Panel Y = Yes, N = No
33	LONG TERM CARE PANEL INDICATOR	X(1)	1		438	438	Yes	No	Long Term Panel Y = Yes, N = No
34	MAIL ORDER PANEL INDICATOR	X(1)	1		439	439	Yes	No	Mail Order Panel Y = Yes, N = No
35	PANEL INDICATOR 6	X(1)	1		440	440	Yes	No	Place holder for future expansion Y = Yes, N = No

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Record Format table									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
36	PANEL INDICATOR 7	X(1)	1		441	441	Yes	No	Place holder for future expansion Y = Yes, N = No
37	PANEL INDICATOR 8	X(1)	1		442	442	Yes	No	Place holder for future expansion Y = Yes, N = No
38	PANEL INDICATOR 9	X(1)	1		443	443	Yes	No	Place holder for future expansion Y = Yes, N = No
39	PANEL INDICATOR 10	X(1)	1		444	444	Yes	No	Place holder for future expansion Y = Yes, N = No
40	TAXONOMY	X(100)	100		445	544	Yes	Yes	Validate that each taxonomy exists within CHAMPS reference tables. Up to 10 taxonomy values can be sent. Each should be 10 chars long and immediately follow each other without any delimiter (space delimited).
41	MANAGING EMPLOYEE FNAME	X(20)	20		545	564	No	No	Store as CHAMPS Office Manager Fname
42	MANAGING EMPLOYEE LNAME	X(30)	30		565	594	No	No	Store as CHAMPS Office Manager Lname

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Record Format: Initial 15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
43	MANAGING EMPLOYEE SSN	X(9)	9		595	603	No	No	Store as CHAMPS Office Manager SSN
44	# OF OWNERSHIP SEGMENTS	9(2)	2		604	605	Yes	Yes	0 <= # <= 20 0 = no owners with at least 5% ownership.
45	# OF OWNERSHIP IN OTHER ENTITIES SEGMENTS	9(2)	2		606	607	Yes	Yes	0 <= # <= 20
46	OWNERSHIP (UP TO 20 OCCURRENCES)	X(10)	10				Yes	Yes	I - Individual/Sole Proprietor P - Partnership C - Corporate CC - Corporate - Charitable 501(c)3 CN - Corporate - Non Charitable G - Government F - Foreign, Nonresident Alien
47	FIRST NAME	X(20)	20				No	Yes	
48	LAST NAME	X(30)	30				No	Yes	
49	SUFFIX	X(10)	10				No	No	

Record Format 103115										
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition	
50	LEGAL ENTITY NAME	X(100)	100				No	Yes		
51	ENTITY BUSINESS NAME (DBA)	X(50)	50				No	Yes		
52	SSN	X(9)	9				No	Yes		
53	EIN/TIN	X(9)	9				No	Yes		
54	PERCENTAGE OWNED (5% OR MORE)	9(3)	3				Yes	Yes	5 <= X <= 100	
55	RELATIONSHIP	X(50)	50				No	Yes	Whole numbers only	
56	START DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes		
57	END DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes		
58	ADDRESS LINE 1	X(55)	55				No	Yes		
59	ADDRESS LINE 2	X(55)	55				No	No		
60	CITY/TOWN	X(50)	50				No	Yes		
61	STATE/PROVINC E	X(30)	30				No	Yes		
62	COUNTY	X(30)	30				No	No		
63	COUNTRY	X(30)	30				No	Yes		

Statement of Understanding (SOU) for Provider File Extract Changes State of Michigan

Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
64	ZIP	X(6)	6				No	Yes	
64.1	ZIP4	X(4)	4				No	No	
65	PHONE NUMBER	X(10)	10				No	Yes	
OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)									
66	OWNER TYPE	X(10)	10				No	Yes	
67	LEGAL ENTITY NAME	X(100)	100				No	Yes	
68	ENTITY BUSINESS NAME (DBA)	X(50)	50				No	Yes	
69	ENTITY EIN/TIN	X(9)	9				No	Yes	
70	PERCENTAGE OWNED (5% OR MORE)	9(3)	3				Yes	Yes	5 <= X <= 100 Whole numbers only
71	RELATIONSHIP	X(50)	50				No	Yes	
72	START DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes	
73	END DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes	
74	ADDRESS LINE 1	X(55)	55				No	Yes	
75	ADDRESS LINE 2	X(55)	55				No	No	

Statement of Understanding (SOU) for Provider File Extract Changes State of Michigan

Record Format: 1951									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
76	CITY/TOWN	X(50)	50				No	Yes	
77	STATE/PROVINC E	X(30)	30				No	Yes	
78	COUNTY	X(30)	30				No	No	
79	COUNTRY	X(30)	30				No	Yes	
80	ZIP	X(6)	6				No	Yes	
80.1	ZIP4	X(4)	4				No	Yes	
81	PHONE NUMBER	X(10)	10				No	Yes	
82	PH-DISENROLL- REASON	X(2)	2				Yes	No	04 -Voluntary Suspension
									05 -Involuntary Suspension
									06 -Voluntary Termination
									07 -Involuntary Termination
									09 -Non-Renewal of License
									10 -Retired
									11 -Deceased
									12 -Closure for Business and Institutions
									14 -Returned Mail
									20 -Change in Ownership
									21 -Provider Left Group
									50 -Re-validation Not Complete

Statement of Understanding (SOU) for Provider File Extract Changes State of Michigan

Record Format: 0103145									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									99 - Terminated for Non-Payment/Auto-Process

Fixed values (35 to 39 will be "N," 41 to 43 will be spaces, and 44 & 45 will be zero)

The end of the record layout will no be included as this information is not available.

Currently being populated in existing extract

3.0 Assumptions

- The level of effort in this document is the final estimate
- Field 10, COUNTY-NAME, was on the old extract and was spaces. This will continue unless otherwise directed.
If we are to populate this field, we will need to define business rules on how to populate this field; e.g., we could use zip code to assign county.
- The new indicator fields look like they are available and we will have to define the business rules for each:
 - ❑ 30 INDEPENDENT PANEL INDICATOR, 31 CHAIN PANEL INDICATOR, 32 IV INFUSION PANEL INDICATOR, 33 LONG TERM CARE PANEL INDICATOR, 34 MAIL ORDER PANEL INDICATOR
- The new field, 40 TAXONOMY, seems to be an available field.
- It does not appear that we have information to populate the Managing Employee name fields: 41 MANAGING EMPLOYEE FNAME, 42 MANAGING EMPLOYEE LNAME, and 43 MANAGING EMPLOYEE SSN. These will be spaces.
- Field 44, # OF OWNERSHIP SEGMENTS, will be set to zero.
"OWNERSHIP (UP TO 20 OCCURRENCES)" fields will not be placed in the extract file:
 - ❑ 46 OWNER TYPE, 47 FIRST NAME, 48 LAST NAME, 49 SUFFIX, 50 LEGAL ENTITY NAME, 51 ENTITY BUSINESS NAME (DBA), 52 SSN, 53 EIN/TIN, 54 PERCENTAGE OWNED (5% OR MORE), 55 RELATIONSHIP, 56 START DATE, 57 END DATE, 58 ADDRESS LINE 1, 59 ADDRESS LINE 2, 60 CITY/TOWN, 61 STATE/PROVINCE, 62 COUNTY, 63 COUNTRY, 64 ZIP, and 65 PHONE NUMBER
- Field 45, # OF OWNERSHIP IN OTHER ENTITIES SEGMENTS, will be set to zero.
"OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)" fields will not be placed in the extract file:
 - ❑ 66 OWNER TYPE, 67 LEGAL ENTITY NAME, 68 ENTITY BUSINESS NAME (DBA), 69 ENTITY EIN/TIN, 70 PERCENTAGE OWNED (5% OR MORE), 71 RELATIONSHIP, 72 START DATE, 73 END DATE, 74 ADDRESS LINE 1, 75 ADDRESS LINE 2, 76 CITY/TOWN, 77 STATE/PROVINCE, 78 COUNTY, 79 COUNTRY, 80 ZIP, 81 PHONE NUMBER, 82 PH-DISENROLL-REASON, 82 PH-DISENROLL-REASON
- Field 82 PH-DISENROLL-REASON was a field in the old extract but it looks like it has been rolled up into "OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)". This appears to be in error and this field will need to be populated. Currently it contains spaces so it is unclear if this needs a value.

- There are some business rules that need to be reviewed. These are for certain hard coded values for certain providers like Indian Reservations and hard coded logic for address line 1 and 2.
- All fields on the header and trailer appear to be possible.

4.0 Constraints

- First Health Services will map the new fields to data elements in FirstRx™ database. The values will be populated in the extract as long as it is available in the source database.

5.0 Issues and Concerns

- Due to time constraints the first test file will be sent only for format testing.

6.0 Scope of Work

- Test and deploy the changes to production. (See *Section 7.0 – Test Plan* for detailed test plan).
- Transmit weekly files using existing mechanisms and schedules.

7.0 Test Plan

- Unit Testing
 - First Health Services' software development team will do the unit testing. The results of the unit testing will be documented for internal use.
- System Testing.
 - First Health Services will perform system testing and will share the results with the State.
- Test File
 - Provide an initial test file with at least 10 records for format testing using the fixed record length and the header and trailer records, and default values identified in the proposed layout.
 - Provide test file with data from FirstRx™ QC database to test and validate values in the FirstRx™ database with the values in the data file.

8.0 Operational Impact

There should be minimal operational impact once changes are moved to production.

9.0 Estimates and Costing

Activities	ETL	Totals	Target Completion Date
Concept	32	32	6/25/09
Planning	24	24	6/25/09
Requirements	48	48	7/7/09
Design	36	36	7/15/09
Construction	60	60	7/27/09
Testing	80	80	8/13/09
Implementation	8	8	8/14/09
Post Implementation	2	2	8/17/09
Total Implementation	290	290	

Estimated Resource Costs			
Resource Type	Hours	Rate	Charges
ETL	290	\$115.00	\$33,350.00
Total Implementation	290		\$33,350.00

Implementation Fee -- The implementation fee for this project is \$33,350.00. The implementation cost will be billed as a one time charge.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF FIRST HEALTH SERVICES CORPORATION.



**Statement of Understanding (SOU)
for the Michigan Department of
Community Health Medical Pharmacy
Management Program**

August 2, 2011

Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule¹ and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

As part of the implementation process for the Medical Pharmacy Management Program, the State of Michigan authorizes Magellan Medicaid Administration to provide the services outlined in Section 2.0 - Scope of Work.

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by the date mutually agreed to between the State of Michigan and Magellan Medicaid Administration.

Authorizing Signatures

State of Michigan	Magellan Medicaid Administration
	
NAME	NAME
Director of Medicaid Program Operations Bureau	President
TITLE	TITLE
8-10-11	8/17/11
DATE	DATE

1.0 Executive Overview

Magellan Medicaid Administration will provide Michigan Department of Community Health (MDCH) a Medical Pharmacy Management program. We will partner with ICORE Healthcare, LLC ("ICORE"), a sister company of Magellan Medicaid Administration, to provide this program. ICORE was founded in 2003 to help state, federal, and commercial payors improve the costs associated with specialty pharmaceuticals, while supporting the quality of care of the plan and program beneficiaries. ICORE occupies a unique competitive position in the specialty pharmacy sector, by virtue of their work with injectable products on both medical and pharmacy benefits.

The core program being offered to MDCH is the cost management of drugs paid under the medical benefit. The scope of this management program includes oncology and oncology support, rheumatoid arthritis, Crohn's disease and psoriasis, intravenous immune globulin (IVIG), and other key drugs paid under the medical benefit. This program has two components.

1. **Reimbursement:** The first component focuses on unit costs. We have a proprietary reimbursement schedule that aligns the provider's interests with those of MDCH and thereby improves the mix of drugs used, such that lower cost agents, when appropriate, are used more frequently.
2. **Claims Edits:** Our technology platform enables management of drugs paid under the medical benefit; specifically, claim entry errors, fraudulent claims, previously paid claims, and off-label drug use are mitigated. These edits are similar to the techniques used in the management of drugs paid under the pharmacy benefit without disrupting workflow in the provider's office.

The potential savings available from this program are substantial. Based on ICORE's thorough analysis of MDCH's claims, we estimate minimum savings of 10 percent (\$2.0M for the broader fee-for-service (FFS) population, with an expected range of \$2M to \$3M additional with the inclusion of Dual Eligibles and CSHCS) for the services selected by MDCH. The potential savings is general in nature and provided for informational purposes. It is not a statement of guarantee.

A unique service provided by this program is the comprehensive clinical management approach for conditions treated with specialty drugs that may lie on either the medical or drug benefits. For example: rheumatoid arthritis has oral therapies covered under the pharmacy benefit (e.g., methotrexate), self injected specialty agents paid under the pharmacy benefit (e.g., Humira, Enbrel), and provider administered infused drugs paid under the medical benefit, such as Remicade and Orencia. Our partnership will enable the management of these costly, equally effective drugs regardless of where the claim is dispensed, administered, or paid. It is now

critical for MDCH to develop and implement an injectable cost management approach, since seven of the top 10 drugs will be specialty agents in the next few years and more than half of these drugs will be paid under the medical benefit. Moreover, the injectable drug pipeline is far more robust than that of traditional oral drugs. As MDCH faces these fundamental market changes, along with budget shortfalls and expanding enrollment, we believe the tools that ICORE and Magellan Medicaid Administration have built will create significant value for MDCH.

2.0 Scope of Work

The State of Michigan authorizes Magellan Medicaid Administration and its affiliate, ICORE, to provide the services outlined in *Section 2.0 - Scope of Work*. This SOU is an amendment to the *Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs agreement #071B0200069*.

Magellan Medicaid Administration proposes to implement its Medical Pharmacy Management Program with MDCH for its fee for service (FFS) membership, currently estimated to be 415,000 members. ICORE thoroughly analyzed claims for this membership to arrive at our \$2M savings estimate. The estimated Dual Eligible (218,000 members) and Children's Special Health Care Services – Title V (CSHCS – 20,200 members) participants, although not included in ICORE's in-depth analysis, will be included in this program. Spend for this population is 2x as high as the above population, and savings for this population will be an additional \$2M to \$3M. We estimate a minimum savings of 10 percent after implementation of the initiatives outlined below.

Objectives

The primary objectives of this SOU are to

- Develop MDCH's strategy and implementation plan for provider administered injectable drugs;
- Provide IT Consulting services to MDCH for claims editing logic necessary for program implementation;
- Decrease spend in specific drug categories by incentivizing use of generic drugs;
- Revise MDCH's fee schedule for generic drugs, effective January 1, 2012 ;
- Ensure provider administered drug claims are paid correctly and fraud is mitigated;
- Communicate the program to MDCH's provider network; and
- Measure and report savings.

Deliverables

Magellan Medicaid Administration will provide MDCH with the following specific deliverables:

Activities	Deliverable	Timing
Strategy Development <ul style="list-style-type: none"> ▪ Review current strategy ▪ Identify improvements to existing strategy ▪ Size improvements ▪ Develop implementation plans ▪ Support implementation 	Provider-administered injectable management strategy meeting and identification of new opportunities for savings	Beginning 10/01/2011
IT Consulting <ul style="list-style-type: none"> ▪ ICORE will license use of its proprietary claims edits to MDCH ▪ ICORE IT staff will work with MDCH and its MMIS vendor to program these edits into their claims payment system 	<ul style="list-style-type: none"> ▪ On-site meetings between ICORE and MDCH to establish review system needs and architecture ▪ Install edit logic 	Beginning 10/01/2011
Reimbursement <ul style="list-style-type: none"> ▪ Create quarterly provider reimbursement fee schedules to encourage use of generics ▪ Support implementation of new fee schedules 	Revised provider-administered injectable reimbursement schedule	Fifth business day of each quarter
Post Service Claims Editing (PSCE) <ul style="list-style-type: none"> ▪ Recommend edits to be installed (see above) ▪ Update editing logic quarterly, on an as-needed basis ▪ Recommend correct payment of units ▪ Recommend correct payment by diagnosis 	Final list of j-codes to be edited (<i>Attachment A</i>)	To be determined
Provider Communication <ul style="list-style-type: none"> ▪ Communicate program to network providers ▪ Gain provider consensus ▪ Conduct provider profiling ▪ Develop generic drug use optimization plan 	Train up to 20 provider group practices on: <ul style="list-style-type: none"> ▪ PSCE ▪ Reimbursement methodology 	Beginning 10/15/2011

Activities	Deliverable	Timing
Measurement <ul style="list-style-type: none"> ▪ Measure program savings ▪ Present savings to MDCH leadership ▪ Measure improvements in drug mix ▪ Report quarterly changes, by provider ▪ Identify new savings opportunities ▪ Size new savings opportunities ▪ Develop implementation plans for new opportunities 	<ul style="list-style-type: none"> ▪ Savings reports ▪ Generic drug use and change over time report by physician ▪ Report of new savings initiatives, implementation plans, and savings size 	Quarterly

Implementation and Operational phase performance standards and guarantees do not apply to services to be provided under this SOU.

3.0 Time Period of Agreement

This agreement will be effective beginning October 1, 2011, and run concurrently with the pharmacy benefits administration contract. The Implementation Phase will begin upon signature of this SOU, but no later than October 1, 2011, assuming that the State of Michigan executes and delivers this SOU on or before such date. The Operational Phase of this Agreement will commence on or about January 1, 2012, assuming that the State of Michigan supplies the required deliverables listed in *Section 4.0 – Pricing and Deliverables, #5* on or before October 15, 2011.

4.0 Pricing and Deliverables

Pricing Components

1. Implementation Fee & Timing: The State of Michigan agrees to reimburse Magellan Medicaid Administration a one-time Implementation Fee of \$100,000.00, to be paid on November 1, 2011. The Implementation phase will begin October 1, 2011, and will conclude on December 30, 2011.
2. Annual Fee and Timing: Magellan Medicaid Administration's annual fee will be applied during the Operational Phase, beginning January 1, 2012. The State of Michigan agrees to reimburse Magellan Medicaid Administration a fee of \$300,000.00 annually for the services provided. For the first year of the contract (October 1, 2011 through March 31, 2012) the prorated fee is \$175,000.00 for services delivered from October 1, 2011 through March 31, 2012. Payments will be made on a monthly basis in the amount of \$25,000.00 per month. Fees listed are considered the minimum necessary to operate this program for MDCH, regardless of services selected.
3. Annual Fee Adjustment: For subsequent contract years, the Annual Fee shall increase by the amount and percentage in the table below. The date of adjustment will coincide with the renewal date of Magellan Medicaid Administration's contract, April 1.

Contract Year	Monthly Fee	Annual Fee	Maximum Annual Fee Adjustment
January 1, 2012 – March 31, 2012	\$25,000	*\$175,000	
April 1, 2012 – March 31, 2013	\$25,943	\$311,310	3.77%
April 1, 2013 – March 31, 2014	\$26,923	\$323,078	3.78%
April 1, 2014 – March 31, 2015	\$27,938	\$335,258	3.77%

* Annual Fee includes Implementation Fee

4. Estimated Annual Savings and Implementation Dates for Services Selected: Based on the services selected by MDCH, program savings are projected to be approximately \$2.0M dollars.
 - ❖ Reimbursement (VFS): January 1, 2012.
 - ❖ Post Service Claims Edits (PSCE): January 1, 2012. Drugs included in the PSCE program are defined in Attachment A.
5. State of Michigan: The following deliverables will be required of the State of Michigan to meet contract implementation deadlines, and operational guidelines throughout the life of this contract:

- ❖ July 15, 2011 – Signature of this SOU
- ❖ Implementation Phase (October 1, 2011-December 31, 2011)
 - Current Fee Schedule of J-coded drugs (by October 15, 2011)
 - Coordination of meetings between Magellan Medicaid Administration and MDCH IT staff (by October 15, 2011) to review and recommend PSCE edits list (Attachment A)
 - Scheduling MDCH internal training meetings on program
 - Scheduling kick-off meetings with key Provider groups
 - Assistance with deliverables outlined in *Section 2.0 – Scope of Work*, where MDCH's input would reasonably be required
- 6. Operational Phase (January 1, 2012 – throughout contract)
 - ❖ Maintenance and updating of PSCE within the MI DCH MMIS system
 - ❖ Assistance with Provider relations
 - ❖ Quarterly teleconferences with Magellan Medicaid Administration on program results and adjustments
 - ❖ Annual Review with Magellan Medicaid Administration staff

Attachment A – HCPCS Codes for PSCE Services

HCPCS Code	Brand Name
J9310	Rituxan
J2353	Sandostatin
J3487	Zometa
J9035	Avastin
J9170	Taxotere
J9217	Lupron
J9264	Abraxane
J9350	Hycamtin
J9001	Doxil
J1561	Gamunex
J9201	Gemzar
J9041	Velcade
J9263	Eloxatin
J1745	Remicade
J9055	Erbitux
J9355	Herceptin
J9202	Zoladex
J3315	Trelstar
J1566	IVIG
J1950	Lupron
J2469	Aloxi
J1441	Neupogen
J9305	Alimta
J2820	Leukine
J0885	Procrit
J9265	Taxol
J9045	Paraplatin

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

January 24, 2011

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (508) 562-2655 Donna M. Mellen	
Magellan Medicaid Administration 4300 Cox Road Glen Allen, VA 23060			
dmmellen@magellanhealth.com		BUYER/CA (517) 241-3768 Lance Kingsbury	
Contract Compliance Inspector: Laura Dotson (517.241.4686) Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH			
CONTRACT PERIOD:		From: April 1, 2010	To: March 31, 2013
TERMS	N/A	SHIPMENT	N/A
F.O.B.	N/A	SHIPPED FROM	N/A
MINIMUM DELIVERY REQUIREMENTS N/A			
MISCELLANEOUS INFORMATION:			

NATURE OF CHANGE(S):

Effective immediately, this Contract is hereby INCREASED by \$254,676.00 and the attached Statement of Understanding is hereby incorporated.

Also, the buyer has been changed to Lance Kingsbury.

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

AUTHORITY/REASON:

Per vendor and agency agreement, Ad Board approval on 1/18/2011, and DTMB/Procurement & Real Estate Services Administration.

INCREASE: \$254,676.00

TOTAL REVISED ESTIMATED CONTRACT VALUE REMAINS: \$20,761,620.00



Statement of Understanding (SOU) for the Michigan Managed Care Rebate Invoicing Program

August 25, 2010

Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule¹ and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

As part of the implementation process for the Managed Care Rebate Invoicing Program, the State of Michigan authorizes Magellan Medicaid Administration to provide the services outlined in Section 2.0 - Detailed Scope of Work.

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by the date mutually agreed to between the State of Michigan and Magellan Medicaid Administration.

Authorizing Signatures

State of Michigan	Magellan Medicaid Administration
	
NAME	NAME
Susan Moran	
TITLE	TITLE
Bureau Director Medicaid Program Operations & Quality Assurance Medical Services Administration Michigan Department of Community Health	
DATE	DATE
8/25/2010	8/25/10

1.0 Executive Overview

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Along with the Health Care and Education Affordability Reconciliation Act of 2010 (signed into law on March 30, 2010), this law will have a significant impact on the Medicaid drug rebates—both Federal and Supplemental.

The PPACA increases the minimum Federal Rebate for single source and innovator multiple source drugs from 15.1 to 23.1 percent and for generic drugs from 11 to 13 percent (the rebate for clotting factors and outpatient drugs approved exclusively for pediatric indications increases from 15.1 to 17.1 percent), effective January 1, 2010. Additionally, the Federal Rebate is now capped at 100 percent of AMP.

This increase in the Federal Rebate is exempt from FMAP (Federal Medical Assistance Percentage) regulations, thus the Federal Government will receive 100 percent of the additional rebate resulting from this law.

In addition to the changes stated above, this law also requires the states to collect CMS level rebates on all Medicaid MCO utilization. According to CMS, the rebate accrual period begins the date the bill was signed into law by President Obama, March 23, 2010.

In order to quickly react to and be in full compliance with this new law, Magellan Medicaid Administration has identified the actions necessary for the State of Michigan to move this initiative forward to meet compliance requirements.

Magellan Medicaid Administration has provided CMS drug rebate services for the State of Michigan since 2002. During this time, we have established a solid working relationship with the State and have developed an understanding of its goals and expectations regarding the CMS rebate program, as well as its supplemental drug rebate program.

Magellan Medicaid Administration core rebate functions will be utilized to support this additional MCO Rebate Invoicing initiative using FirstRebate™, our proprietary and MITA-aligned rebate administration tool that allows for invoicing and allocation for rebates on all drug claims, regardless of source. Medicaid MCO drug utilization is invoiced and posted at an NDC/year/quarter level. In addition to providing a complete accounting of all invoices and collections, FirstRebate™ also allows for:

- Complete tracking of rate changes and utilization adjustments (i.e., voids/reversals)
- Thirteen-week T-bill rates used for interest accrual calculations
- Provider and labeler demographics
- 340B/PHS providers, HCPCS Code/NDC conversion tables

- Dispute resolution functions.

Magellan Medicaid Administration has the necessary rebate experience, and the existing tools and infrastructure are in place to quickly and successfully implement these new MCO Rebate requirements. With the experience of Magellan Medicaid Administration, Michigan will receive a complete solution designed to meet the requirements of the new law. The total estimated saving including state and federal share combined for Michigan is \$120,000,000. This is based on The Lewin Group study dated September 22, 2008 titled “*Analysis of Drug Rebate Equalization Act’s Savings to the Medicaid Program.*”

2.0 Detailed Scope of Work

The major functions and activities that are part of the Managed Care Rebate Invoicing Program that affect the State CMS rebate program are the Implementation activities necessary to interface, test, and report on MCO utilization data and the ongoing quarterly services necessary to process, invoice, collect, and report the additional drug utilization data for each MCO. The primary activities for this initiative are as follows:

Implementation

- **Data Interface** - Magellan Medicaid Administration has developed a standard data interface program; the required MCO data elements are provided in Attachment A. Any non-standard interface files will require customized programming and are not included in the prices contained in this SOU. Additional support for activities necessary to support submission of non-standard interface files will be performed at an all-inclusive hourly rate of \$135.00 per hour.
- **Testing** - The aggregated MCO data interface file provided by the State will be tested and validated. Communication between the State and our test team will be needed to work through any data issues to finalization. Validated MCO data interface file will be run through a test environment to simulate all FirstRebate™ processing and resultant reporting.
- **Reporting** - All existing reporting will be verified and reviewed with the State for final approvals. Magellan Medicaid Administration’s standard rebate reports will be utilized to support this Managed Care Rebate Invoicing Program. Any additional or customized reports are not included in the prices contained in this SOU. Additional support for activities necessary to support customized reporting and ad hoc reporting will be performed at an all-inclusive hourly rate of \$135.00 per hour.

Operations

- **Rebate Billing** - Based on claims processed by the MCO, Magellan Medicaid Administration will receive drug utilization data from Michigan on a monthly basis or

more frequently if available using the specified file format described in Attachment A. MCOs will be required to pass NDC level information including J-code conversions consistent with CMS regulations. Utilization data will be aggregated quarterly and invoiced to the appropriate manufacturers using the quarterly CMS Federal URA. The manufacturers will submit payment to Magellan Medicaid Administration in the same fashion that CMS rebates are submitted today. Invoicing of manufacturers will be done within CMS guidelines. One hundred percent of the rebates pass through to the State.

- **Reconciliation and Reporting** - Magellan Medicaid Administration will maintain quarterly unit rebate amounts data back to the first quarter of 1991 (or future CMS-mandated dates) as provided on the quarterly CMS tape and use those rates for the manufacturer billing. In addition, DCH will be provided the standard rebate report package that is in production today for its FFS programs. This will allow for support of the Federal CMS reporting in the MCO programs. Future requirements from CMS, in regards to rate, rebate offset or FMAP calculations will be provided through the Change Management Process or independent SOU.
- **Limited Dispute Resolution** - Magellan Medicaid Administration will provide claims level detail to manufacturers to assist in dispute resolution. We will work with the MCOs to resolve disputes related to unit discrepancies. However, since we are not the point-of-sale claims processor, resolution of unit disputes will be dependant upon the level of MCO cooperation. Magellan Medicaid Administration assumes that State assistance will be required from time-to-time to assist with dispute resolution.
- **Current Applications** - Magellan Medicaid Administration will modify the existing rebate application currently used to support the Magellan Medicaid Administration Rebate, Diabetic Supply, and Preferred Drug List (PDL) programs to support MCO invoicing activities described above and in compliance with the Managed Care Rebate Invoicing Program.
- **Operational Ad Hoc Reporting** – In order to report individual MCO information, please refer to Attachment B that houses the Location Code relationship to each MCO. This will be a required field in order to perform any ad hoc reporting. Operational ad hoc reporting will be done at the all-inclusive hourly rate of \$135 per hour.

3.0 Time Period of Agreement

This agreement will be effective beginning August 2010 and running through March 31, 2013. The Implementation Phase will begin when the SOU is signed. Rebates will begin to be invoiced and collected for the quarter the period beginning March 23, 2010. This time period coincides with the term of the existing contract between Magellan Medicaid Administration and the State of Michigan.

4.0 Pricing and Deliverables

The Managed Care Rebate Invoicing Program initiative pricing contains three components and is based on the assumption of the State aggregating and providing Magellan Medicaid Administration with the 14 Medicaid MCOs drug utilization. The following list of Medicaid MCOs is applicable:

- BlueCaid of Michigan
- CareSource of Michigan
- Great Lakes Health Plan
- Health Plan of Michigan
- HealthPlus Partners, Inc.
- McLaren Health Plan
- Midwest Health Plan
- Molina Healthcare of Michigan
- Physicians Health Plan of Mid-Michigan
- Priority Health Government Programs, Inc.
- ProCare Health Plan
- Total Health Care
- Omnicare
- Upper Peninsula Health Plan

Pricing Components

1. One-time Implementation Fee of \$48,009 based on the State of Michigan providing aggregated MCO utilization data according to the record layouts in Attachments A and B. This implementation fee of \$48,009 will be due on the agreed upon implementation date.
2. Annual Processing Fee - In exchange for delivering the Managed Care Rebate Invoicing Program services described in this SOU, the State of Michigan agrees to reimburse Magellan Medicaid Administration \$80,000.000 per year. Michigan's annual fee is \$80,000 for the 12 months beginning upon the agreed upon implementation date for the services provided. Payments will be made on a monthly basis in the amount of \$6,666.67 per month.
3. Staffing to be sufficient to collect, aggregate, invoice, and reconcile payments. The following tiered staffing will be used.

Number of MCO Entities	Staffing
One to four	Data Entry Specialist (1 FTE) Pharmacy Services Analyst (1 FTE)
Five to ten	Data Entry Specialist (1 FTE) Pharmacy Services Analysts (2 FTEs)
Eleven or more	Data Entry Specialist (1 FTE) Pharmacy Services Analysts (3 FTEs)

The program will start on the first month of the quarter in which rebates are invoiced.

Attachment A

FirstRebate™ Claim Layout

The standard Magellan Medicaid Administration Claim File Data Format to support Rebate Billing for the MCO Managed Care Rebate Invoicing Program is shown in the following table. A Tag File is required to validate transmission record count for claims. "ST" will be replaced with the State abbreviation in file name. The file naming convention is ST_RBTEXT_YYYYMMDD.TXT.

Number	Column Name	Type and Size	Start	End	Description	Defaults
1.	CLIENT_ID	INTEGER (4)	1	4	Client ID. Please populate with 0003.	Required
	FILLER	CHAR(1)	5	5	Space is the delimiter	Required
2.	ICN	CHAR (20)	6	25	Claim number	Required
	FILLER	CHAR(1)	26	26	Space is the delimiter	Required
3.	CLAIM_LINE_NO	INTEGER (4)	27	30	Claim line number	Required
	FILLER	CHAR(1)	31	31	Space is the delimiter	Required
4.	STATUS	CHAR (1)	32	32	O - Original V - Void	Required
	FILLER	CHAR(1)	33	33	Space is the delimiter	Required
5.	YRQTR	CHAR (5)	34	38	Year and Quarter the claim is applied. For Void claims, YRQTR would be the same as the original claim. YYYYYQ	Required
	FILLER	CHAR(1)	39	39	Space is the delimiter	Required

Number	Column Name	Type and Size	Start	End	Description	Defaults
6.	NDC	CHAR (11)	40	50	National Drug Code	Required for Pharmacy
	FILLER	CHAR(1)	51	51	Space is the delimiter	Required
7.	UNITS	DECIMAL(12, 3)	52	65	Metric decimal quantity of NDC dispensed. +123456789.123 or -123456789.123	Required
	FILLER	CHAR(1)	66	66	Space is the delimiter	Required
8.	PAID_AMT	DECIMAL(11, 2)	67	79	Total amount to be paid by the claims processor. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	80	80	Space is the delimiter	Required
9.	BILLED_AMT	DECIMAL(11, 2)	81	93	Provider submitted +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	94	94	Space is the delimiter	Required
10.	PROVIDER_ID	CHAR (15)	95	109	National Provider Identifier for the billing provider (e.g. pharmacy or medical provider)	Required
	FILLER	CHAR(1)	110	110	Space is the delimiter	Required
11.	PRESCRIB_PROVIDER	CHAR (15)	111	125	Prescribing provider for pharmacy claims	Required
	FILLER	CHAR(1)	126	126	Space is the delimiter	Required
12.	DATE_OF_SERVICE	SMALLDATETIME	127	136	Date of service- fill date of claim MM/DD/YYYY	Required
	FILLER	CHAR(1)	137	137	Space is the delimiter	Required
13.	RECIPIENT_ID	CHAR (15)	138	152	Patient ID	Required
	FILLER	CHAR(1)	153	153	Space is the delimiter	Required
14.	RX_NBR	CHAR (10)	154	163	Prescription Number	Required for Pharmacy Optional for JCODE
	FILLER	CHAR(1)	164	164	Space is the delimiter	Required
15.	PROC_CODE	CHAR (7)	165	171	Procedure code for medical claims (HCPC)	Required for JCODE Optional for Pharmacy

Number	Column Name	Type and Size	Start	End	Description	Defaults
	FILLER	CHAR(1)	172	172	Space is the delimiter	Required
16.	TPL_AMT	DECIMAL(11, 2)	173	185	Third party paid amount. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	186	186	Space is the delimiter	Required
17.	COPAY_AMT	DECIMAL(11, 2)	187	199	Amount to be collected from a patient due to a per prescription co-pay/co-insurance. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	200	200	Space is the delimiter	Required
18.	PAID_DATE	SMALLDATETIME	201	210	Date claim was paid MM/DD/YYYY	Required
	FILLER	CHAR(1)	211	211	Space is the delimiter	Required
19.	DATE_RECVD	SMALLDATETIME	212	221	Date claim was received (loaded) by Magellan Medicaid Administration. MM/DD/YYYY Unique date for the whole extract/file when it was created	Required
	FILLER	CHAR(1)	222	222	Space is the delimiter	Required
20.	DAW	CHAR (1)	223	223	Dispense as written indicator	Required
	FILLER	CHAR(1)	224	224	Space is the delimiter	Required
21.	COMPOUND_IND	CHAR (1)	225	225	Y or N	Required; Default to 'N' if not a compound claim
	FILLER	CHAR(1)	226	226	Space is the delimiter	Required
22.	EXCLUSION_RSN	CHAR (1)	227	227	Magellan Medicaid Administration defined field.	
	FILLER	CHAR(1)	228	228	Space is the delimiter	Required
23.	DAYS_SUPPLY	INTEGER(4)	229	232	The number of days of therapy that the claimed drugs will supply.	Required
	FILLER	CHAR(1)	233	233	Space is the delimiter	Required
24.	SOURCE_CD	CHAR (3)	234	236	Claim Source POS = Point of Sale JCD = Medical	Required
	FILLER	CHAR(1)	237	237	Space is the delimiter	Required

Number	Column Name	Type and Size	Start	End	Description	Defaults
25.	DISPENSE_FEE	DECIMAL(5, 2)	238	244	Dispensing fee submitted by pharmacy. +123.12 or -123.12	Optional
	FILLER	CHAR(1)	245	245	Space is the delimiter	Required
26.	REFILL_CD	CHAR (2)	246	247	Provider submitted fill number	Optional
	FILLER	CHAR(1)	248	248	Space is the delimiter	Required
27.	INVOICE_YR_QTR	CHAR (5)	249	253	Year and quarter claim is paid or voided. YYYYQ; Derive based on paid date	Required
	FILLER	CHAR(1)	254	254	Space is the delimiter	Required
28.	PROGRAM_ID	CHAR (3)	255	257	Unique ID to distinguish different Client Use MIO	Required
	FILLER	CHAR(1)	258	258	Space is the delimiter	Required
29.	GROUP_ID	VARCHAR(15)	259	273	Recipient Group Code Group Associated to a Recipient ID	Optional
	FILLER	CHAR(1)	274	274	Space is the delimiter	Required
30.	FUND_CODE	VARCHAR (2)	275	276	Funding source	Optional
	FILLER	CHAR(1)	277	277	Space is the delimiter	Required
31.	TOWN_CODE	CHAR(4)	278	281	Recipient/Provider city code In case of a Future Report	Optional
	FILLER	CHAR(1)	282	282	Space is the delimiter	Required
32.	LOCATION_CODE	CHAR (2)	283	284	MCO entity (see attachment B below)	Required
	FILLER	CHAR(1)	285	285	Space is the delimiter	Required
33.	ORIGINAL_PROVIDER_ID	CHAR (15)	286	300	Provider ID prior to NPI implementation. For void claims the ID of the original claims (NABP/Medicaid/NPI)	Required

Tag File

A Tag File is a small text file that contains information about a specific data file. A Tag File must accompany each data file transmitted to Magellan Medicaid Administration's Rebate staff in order for MMA to catalogue and process the data content included in the submission.

Magellan Medicaid Administration only processes data files and tag files in pairs. Orphaned data files or Tag Files will not be processed.

The data supplier should provide the following content in the Tag Files:

Field Name	Data Type	Size	Comments	Defaults
Record count	Integer	10	Identifies the number of records included in the data content file	
Filler	Char	1	Pipe() is the delimiter	
Transmission Date	Char	10	Identifies the date the file was sent	
Filler	Char	1	Pipe() is the delimiter	
Contact Name	Char	30	Provides contact name information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Contact Phone	Char	12	Provides contact phone information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Contact Email	Char	30	Provides contact email information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Comments	Char	50	Provides space for comments regarding the data content, such as data type, or special instructions, etc.	

Attachment B

Location Code	MCO Entity
01	BlueCaid of Michigan
02	CareSource of Michigan
03	Great Lakes Health Plan
04	Health Plan of Michigan
05	HealthPlus Partners, Inc.
06	McLaren Health Plan
07	Midwest Health Plan
08	Molina Healthcare of Michigan
09	Omnicare Health Plan
10	Physicians Health Plan of Mid-Michigan - Family Care
11	Priority Health Government Programs, Inc.
12	ProCare Health Plan
13	Total Health Care
14	Upper Peninsula Health Plan

FirstRebate™ Provider Layout

The standard Magellan Medicaid Administration Provider Data Format to support Rebate Billing for the Managed Care Rebate Invoicing Program is shown in the following table. “ST” will be replaced with the State abbreviation in the file name. The file naming convention is ST_RBPROV_YYYYMMDD.TXT. A Tag File is required to validate transmission record count for claims.

Field Name	Data Type	Size	Comments	Defaults
Client ID	Integer	4	Magellan Medicaid Administration assigned client id number	Magellan Medicaid Administration assigned client ID number Please populate with _0003__
Filler	Char	1	Semi colon is the delimiter	Required
Provider ID	Char	15	The NPI Pay-to-provider for medical claims. What If I do not have an NPI? Medicaid # can be	Required

Field Name	Data Type	Size	Comments	Defaults
			sent.	
Filler	Char	1	Semicolon is the delimiter	Required
Name	Char	50	Provider Name (e.g. Pharmacy or Medical Provider)	Required
Filler	Char	1	Semicolon is the delimiter	Required
Address 1	Char	50	Provider Mailing Address	Required
Filler	Char	1	Semicolon is the delimiter	Required
Address 2	Char	50	Provider	Optional
Filler	Char	1	Semicolon is the delimiter	Required
City	Char	30	Provider City	Optional
Filler	Char	1	Semicolon is the delimiter	Required
State - Abbreviation	Char	2	Provider State	Optional
Filler	Char	1	Semicolon is the delimiter	Required
ZIP Code	Char	9	Provider ZIP Code	Optional
Filler	Char	1	Semicolon is the delimiter	Required
Phone No.	Char	10	Provider Phone Number	Optional

Tag File

A Tag File is a small text file that contains information about a specific data file. A Tag File must accompany each data file transmitted to Magellan Medicaid Administration Rebate staff in order for Magellan Medicaid Administration to catalogue and process the data content included in the submission.

Magellan Medicaid Administration only processes data files and Tag Files in pairs. Orphaned data files or Tag Files will not be processed.

The data supplier should provide the following content in the Tag Files:

Field Name	Data Type	Size	Comments	Defaults
Record count	Integer	10	Identifies the number of records included in the data content file	
Filler	Char	1	Pipe() is the delimiter	
Transmission Date	Char	10	Identifies the date the file was sent	
Filler	Char	1	Pipe() is the delimiter	

Field Name	Data Type	Size	Comments	Defaults
Contact Name	Char	30	Provides contact name information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Contact Phone	Char	12	Provides contact phone information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Contact Email	Char	30	Provides contact email information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe() is the delimiter	
Comments	Char	50	Provides space for comments regarding the data content, such as data type, or special instructions, etc.	

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

July 23, 2010

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (508) 562-2655 Donna M. Mellen	
Magellan Medicaid Administration 4300 Cox Road Glen Allen, VA 23060			
dmmellen@magellanhealth.com		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Laura Dotson (517.241.4686) Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH			
CONTRACT PERIOD:		From: April 1, 2010	To: March 31, 2013
TERMS	N/A	SHIPMENT	N/A
F.O.B.	N/A	SHIPPED FROM	N/A
MINIMUM DELIVERY REQUIREMENTS N/A			
MISCELLANEOUS INFORMATION:			

NATURE OF CHANGE(S):

Effective July 1, 2010, First Health Services Corporation will officially operate under the name of Magellan Medicaid Administration. The Contractor address and FEIN will remain the same.

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

AUTHORITY/REASON:

Per Contractor request (letter dated 5/17/2010), and DTMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: \$20,506,944.00