

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE FOR
THE STATE OF MICHIGAN,

Petitioner,

Case No. 98-88265-CR

HON. JAMES R. GIDDINGS

v

MICHIGAN HEALTH MAINTENANCE
ORGANIZATION PLANS, INC., a Michigan
health maintenance organization, doing
business as OmniCare Health Plan,

Respondent.

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**BRIEF TO PRESERVE OPPORTUNITY TO BE HEARD
AND REGARDING CLASSIFICATION OF CLAIMS**

The Department of Community Health (DCH) files this submission in the above captioned matter to preserve an opportunity to address the Court at the July 20, 2005, hearing

regarding how claims in this liquidation will be classified under Chapter 81 of the Insurance Code. As well, incorporated are the substantive arguments made by the DCH in its proof of claim seeking a higher priority status:

FACTUAL BASIS OF PROOF OF CLAIM

The Department of Community Health (DCH) files this claim against Michigan Health Maintenance Organization Plans, Inc., (the HMO) on the basis of state law that requires the DCH to assess a quality assurance assessment (QAA) on every health maintenance organization that has a Medicaid managed care contract awarded by the state. MCL 500.224b(2)(c). The QAA equals 6% of non-medicare premiums collected by the HMO as based on the most recent financial statement filed with the Insurance Commissioner. MCL 500.224b(1), (2)(b).

During the period of January 1, 2004 to September 30, 2004, the HMO had a Medicaid managed care contract awarded by the state. Attachment A, Tab 6. In accordance with state law, the HMO was assessed the QAA during that time period. The DCH invoiced the HMO for the amount of \$2,562,875.00 which equals 6% of \$42,714,587.00. The \$42,714,587.00 amount is the result of subtracting federal employee health benefit premiums from net premium income indicated in the HMO Quarterly Statement to the Insurance Commissioner for quarter ended March 31, 2004. Attachment B. Net premium income in the amount of \$44,637,072.00 is found on page 4, line 2 of Attachment B, and federal employee health benefit premiums in the amount of \$1,922,485.00 is found on page 7, column 7, line 12 of that Attachment. The HMO Quarterly Statement to the Insurance Commissioner for quarter ended September 30, 2004 on page 3, line 9 of Attachment C shows the expense of the principal amount of the QAA for the current invoice. But the HMO did not pay that amount and as a result the DCH added a late payment penalty of 5% for each month that payment of the assessment and penalty were late. MCL 500.224b(2)(f) authorizes imposition of the 5% penalty. The DCH then sent another invoice

requiring payment of the QAA in the principal amount of \$2,562,875.00, and a penalty of \$384,431.25, (representing 3 months of non-payment at 5% per month) for a total of \$2,947,306.25. Attachment D.

(Note regarding attachments. Only the cover pages of the contracts are provided. Specific pages from the contract for substantiating this proof of claim will be attached where indicated below. The entire contract, which is voluminous, will be provided upon request. Similarly, only the pertinent pages from OmniCare Health Plan's quarterly statements are provided. The entire statements will be provided if requested.)

1. The Quality Assurance Assessment Program

The QAA was implemented on May 10, 2002. MCL 500.224b(2)(a). Federal law governs states' administration of quality assurance assessments. 42 USC 1396b(w).

The purpose of the Quality Assurance Assessment Program (QAAP) is to increase the pool of funds available for Medicaid payments to health maintenance organizations, hospitals, and long-term care facilities that provide medical care to enrollee-patients. The increase in the pool of funds is achieved through a federal matching funds program attributed to each dollar of the quality assurance assessment collected. MCL 500.224b(2). The QAA and the federal matching funds are put back into the Medicaid program for subsequent disbursement to health maintenance organizations, hospitals, and long-term care facilities.

By increasing the federal funds available, the DCH is able to increase the rates of reimbursement/payments for the costs of care provided to Medicaid eligible enrollees. This purpose is designed to meet the rising costs of medical care and to ensure that Medicaid eligible enrollees of health maintenance organizations, hospitals, and long-term care facilities receive medical care that they could not otherwise for lack of other insurance or personal financial resources.

For every dollar of the QAA not collected there is a corresponding lost dollar of federal matching funds. Lost federal funds diminish the financial resources available to pay health maintenance organizations, hospitals, and long-term care facilities for quality of care that can be provided to Medicaid eligible enrollees, i.e., the elderly, the disabled, low income earners, children.

2. The Insurance Code, Chapter 81, Supervision, Rehabilitation, and Liquidation

Chapter 81 of the Insurance Code is to be liberally construed to effect its purpose--to protect the interests of insureds, claimants, creditors, and the public. MCL 500.8100(2) and (3).

a) Argument for Change of Class Priority for Distribution pursuant to MCL 500.8142

The class priority for distribution of assets of an HMO undergoing liquidation is statutorily set. MCL 500.8142. Typically a claim by any state is set as a class 6 priority. MCL 500.8142(1)(f). Class 6 priority claims also include any penalty to the extent of the pecuniary loss sustained.

The basic premise for classifying this proof of claim as to the principal amount of the QAA at a priority level to ensure the DCH receives some amount on its claim, other than as Class 6, is this: the monies at issue are for helping the state's neediest citizens obtain necessary medical care. These insureds should be protected by a liberal construction of Chapter 81.

Regarding the late payment penalty included in the invoice for the QAA, the DCH submits that the penalty is properly classified as a Class 6 priority. Because the HMO failed to pay the QAA there is a direct corresponding loss in the ability of the DCH to obtain federal matching funds in the amount of the principal of the QAA.

With respect to the principal amount of the QAA, \$2,562,875.00, the DCH seeks to fit the principle amount into either the Class 1 priority as a cost of preserving the insurer's assets, MCL 500.8142(1)(a)(i), or in the alternative as a Class 5 priority—claim of a general creditor, MCL

500.8142(1)(e). In the event the arguments for reclassification are unpersuasive, then the entire amount should be classified as a Class 6 priority—a state claim, MCL 500.8142(1)(f).

b) Class 1 Priority for the principal amount of the QAA is appropriate as a cost of preserving the HMO's assets.

MCL 500.8142(1)(a) establishes as a Class 1 priority the “costs and expenses of administration, including, but not limited to,” the actual and necessary costs of preserving the insurer's assets.

The DCH submits that it played a significant financial role in the administration of the HMO during the period of rehabilitation before the order for liquidating receivership.

The DCH was aware of the HMO's financial problems in 2001 when the HMO went into rehabilitation. Still for another 3 years the DCH continued to extend the Medicaid managed care contract it had entered into with the HMO. This contract helped the HMO preserve its current enrollees and made the HMO much more attractive to potential enrollees. As well the HMO was better able to retain its relationships with third-party medical care providers and probably gained new third-party medical care providers to service Medicaid eligible enrollees. In addition, by participating in the Medicaid managed care contract the HMO was entitled to receive increased rates of reimbursement/payments for the costs of care provided to Medicaid eligible enrollees.

By this continual contractual relationship with the HMO, the DCH helped the HMO retain some level of economic viability so that it could provide coverage for Medicaid eligible enrollees, and worked with the HMO during rehabilitation with the goal that the HMO would come out of rehabilitation as an on-going insurer. In this regard then, the DCH helped administer in preserving the assets of the HMO, although, with the original intent of having the HMO continue operations indefinitely rather than for purposes of preserving an asset base for liquidation proceedings. The fact that the help provided by the DCH to the HMO was for a purpose other than merely preserving an asset base for these liquidation proceedings should not

be a basis on which to deny this Class 1 priority to this proof of claim. Therefore, the principal amount of the QAA, \$2,562,875.00, ought to be deemed a Class 1 claim for purposes of distribution of the assets.

c) Alternatively, Class 5 Priority for the principal amount of the QAA is appropriate because the DCH contracted for a purchase of services from the HMO making the DCH a general creditor.

MCL 500.8142(1)(5) provides that a Class 5 priority claim includes “any claims of general creditors.”

The DCH submits that if its claim is not qualified as a Class 1 priority claim then on the basis of its contractual relationship with the HMO the QAA principal amount should be classified as a claim of a general creditor.

The contract between the DCH and the HMO states as its purpose that the DCH was purchasing services of the HMO to provide comprehensive health care to Medicaid beneficiaries. Attachment A, Tab 2, Section I-A, p1. Similarly, see Section II-A, p 13, Background/Problem Statement. This relationship is more formally stated in Section I-BB, p 11. It provides in pertinent part that the State is the client of the independent contractor HMO.

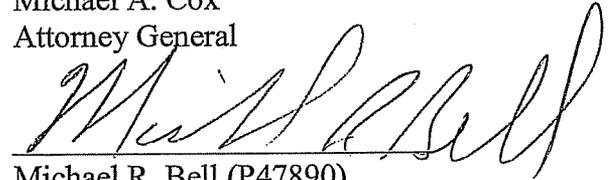
The HMO by entering into the contract agreed to pay the QAA (as mandated by MCL 500.224b) for the period it was under contract, July 1, 2004 through September 30, 2004. In return for this payment, the DCH paid an enhanced reimbursement rate. Because the DCH performed its role under the contract for this period, the HMO was likewise obligated to perform. Regarding the last invoice, it has not done so. That gives rise to the general creditor claim.

d) Finally, if the prior arguments fail to persuade the liquidator to reclassify this proof of claim than Class 6 is appropriate.

MCL 500.8142(1)(f) provides for state claims being paid under Class 6. The DCH is a principal department of the State of Michigan. MCL 330.3101. In terms of the liquidation of the HMO, the DCH is submitting this proof of claim on behalf of the state.

Respectfully submitted,

Michael A. Cox
Attorney General



Michael R. Bell (P47890)
Assistant Attorney General

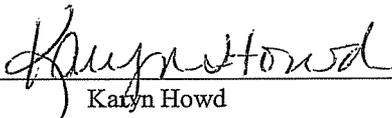
Attorney for Respondent
Michigan Dept of Community Health

BUSINESS ADDRESS:
525 W. Ottawa Street, Second Floor
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Lansing, Michigan 48909
(517) 373-3203

Dated: June 24, 2005
2005000263a/Brief

Proof of Service

The undersigned certifies that a copy of the foregoing document(s) was served upon the attorneys of record or parties appearing in pro per in the above cause by mailing the same to them at their respective address(es) with postage fully prepaid thereon, on the 24th day of June, 2005.

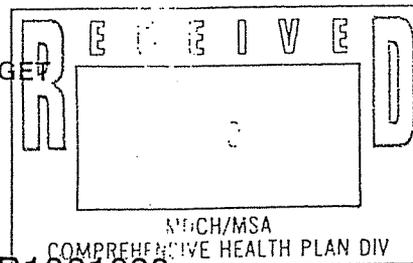


Katyn Howd

A

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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



CONTRACT NO. 071B1001038

between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
Contract Administrator: Rick Murdock Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health		BUYER (517) 373-2467 Ray E. Irvine
CONTRACT PERIOD: From: October 1, 2000		To: October 1, 2002*
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		
MISCELLANEOUS INFORMATION: The terms and conditions of this Contract are those of ITB #07110000251, this Contract Agreement and the vendor's quote dated 5-1-00, and subsequent Best And Final Offer. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence. Estimated Contract Value: The exact dollar value of this contract is unknown; the Contractor will be paid based on actual beneficiary enrollment at the rates (prices) specified in Attachment A to the Contract		

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No.07110000251. A Purchase Order Form will be issued only as the requirements of the State Departments are submitted to the Office of Purchasing. Orders for delivery may be issued directly by the State Departments through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:

OMNICARE HEALTH PLAN
 Firm Name
Meg H. Moses
 Authorized Agent/Signature
GREGORY H. MOSES JR
 Authorized Agent (Print or Type)
9/18/2000
 Date

FOR THE STATE:

David F. Ancell
 Signature
 David F. Ancell
 Name
 State Purchasing Director
 Title
10/6/06
 Date

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

October 10, 2000

NOTICE
 TO
 CONTRACT NO. 071B1001038
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
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Estimated Contract Value: The exact dollar value of this contract is unknown; the Contractor will be paid based on actual beneficiary enrollment at the rates (prices) specified in Attachment A to the Contract

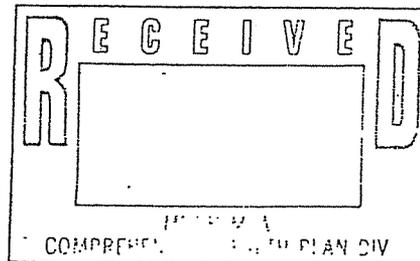


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DEFINITIONS/EXPLANATION OF TERMS

ACIP	Advisory Committee on Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
Balanced Budget Act	The Balanced Budget Act (BBA) of 1997 (Public law 105-33) was signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare and Medicaid Programs since their inception. Additionally, it expands the services provided through the new Child Health Insurance Program (Title XXI).
Beneficiary	Any person determined eligible for the Medical Assistance Program as defined below.
Blanket Purchase Order	Alternative term for "Contract" used in the State's computer system (Michigan Automated Information Network) MAIN.
Business Day	Monday through Friday except those days identified by the State as holidays.
CAC	Clinical Advisory Committee appointed by the DCH.
Capitation Rate	A fixed per person monthly rate payable to the Contractor by the DCH for provision of all Covered Services defined within this Contract. This rate shall not exceed the limits set forth in 42 CFR 447.361.
CFR	Code of Federal Regulations
CHCP	Comprehensive Health Care Program. Capitated health care services for Medicaid Beneficiaries in specified counties provided by Contractors that contract with the State.
Clean Claim	For purposes of this Contract, a Clean Claim shall be defined as in the Medicare Program unless otherwise defined by State or Federal enacted legislation. A Clean Claim is one that does not require further investigation or the development of additional information outside of the Contractor's operation before processing the claim. Clean Claims also are those that: <ul style="list-style-type: none"> • Pass edits and are processed electronically; • Do not require external development; • Are investigated within the Contractor's claims, medical review or payment office without the need to contact the provider, Enrollee or other outside source; <p>Are subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the Contractor's</p>



DEFINITIONS/EXPLANATION OF TERMS (*con't.*)

Clean Claim (*con't.*)

- instructions;
 - Identifies the health professional or the health facility that provided treatment or service and includes a matching identifying number (provider ID number);
 - Identifies the patient and plan (member ID number andn plan name and/or ID number);
 - Lists the date and place of service;
 - Is for covered services;
 - If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required;
 - Includes additional documentation based upon services rendered as reasonably required by the payer;
- Is certified by the provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim.

CMHSP

Community Mental Health Services Program

Contract

A binding agreement between the State of Michigan and the Contractor (see also "Blanket Purchase").

Contractor

A successful Bidder who is awarded a Contract to provide services under CHCP. In this Contract, the terms Contractor, Contractor's plan, Health Plan, Qualified Health Plan, and QHP, are used interchangeably.

Covered Services

All services provided under Medicaid, as defined in Section II-H (1)-(2) that the Contractor has agreed to provide or arrange to be provided.

CSHCS

Children's Special Health Care Services.

DCH or MDCH

The Department of Community Health or the Michigan Department of Community Health and its designated agents.

Department

The Department of Community Health and it designated agents.

DMB

The Department of Management and Budget.

Emergency Medical Care/Services

Those services necessary to treat an emergency medical condition. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person,



DEFINITIONS/EXPLANATION OF TERMS (con't.)

Emergency Medical Care/Services (con't.)	with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
Enrollee	Any Medicaid Beneficiary that is a member of the Contractor's health plan (see Beneficiary)
Enrollment Capacity	The number of persons that the Contractor can serve through its provider network under a Contract with the State. <u>Enrollment Capacity</u> is determined by a Contractor based upon its provider network and organizational capacity. The DCH will verify that the provider network is under contract and of sufficient size before accepting the <u>enrollment</u> capacity statement.
Enrollment Service	An entity contracted by the DMB to contact and educate general Medicaid and Children's Special Health Care Services Beneficiaries about managed care and to enroll, disenroll, and change enrollment(s) for these Beneficiaries.
FIA	Family Independence Agency, formerly the Department of Social Services.
FFS	Fee-for-service. A reimbursement methodology that provides a payment amount for each individual service delivered.
FQHC	Federal Qualified Health Center
Health Plans	Managed care organizations that provide or arrange for the delivery of comprehensive health care services in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent or kind of health care services. A Health Plan must be licensed as a Health Maintenance Organization (HMO) not later than October 1, 2000. (See also "Contractor.")
HEDIS	Health Employer Data and Information Set.
HCFA	The Health Care Financing Administration (and its designated agents) which is the federal agency within the United States Department of Health and Human Services responsible for administration of the Medicaid and Medicare programs.
HMO	An entity defined in Michigan Compiled Laws (MCL 333.21005(2)) that has received and maintains a state license to operate as an HMO.



DEFINITIONS/EXPLANATION OF TERMS (con't.)

Long Term Care Facility	Any facility licensed and certified by the Michigan Department of Community Health, in accordance with 1978 PA 368, as amended, to provide inpatient nursing care services.
Medicaid/Medical Assistance Program	A federal/state program authorized by the Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and section 105 of 1939 PA 280, as amended, MCL 400.105; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.
MSA	Medical Services Administration, the agency within the Department of Community Health responsible for the administration of the Medicaid Program.
PCP	Primary Care Provider. Those providers within the Health Plans who are designated as responsible for providing or arranging health care for specified Enrollees of the Contractor. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician when appropriate for an Enrollee, other physician specialists when appropriate for an Enrollee's health condition, nurse practitioner, and physician assistants.
PMPM	Per Member Per Month.
Provider	Provider means a health facility or a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.6101-333.6523 and MCL 333.16101-333.18237.
Purchasing Office	The Office of Purchasing within the Department of Management and Budget that is the sole point of contact throughout the procurement process.
QIC	Quality Improvement Committee appointed by the Contractor.
QHP	A Qualified Health Plan awarded a Contract to provide services under CHCP. (See also "Contractor").
RFP	Request for Proposal. Interchangeable with ITB, (Invitation to Bid). A procurement document that describes the services required, and instructs prospective Bidders how to prepare a response.



DEFINITIONS/EXPLANATION OF TERMS (con't.)

Rural	Rural is defined as any county not included in a standard metropolitan area (SMA).
Successful Bidder	The Bidder (Contractor) awarded a Contract as a result of a proposal submitted in response to the ITB.
State	The State of Michigan.
State Purchasing Director	The Director of the Office of Purchasing within the Department of Management and Budget. Also referred to as Director of Purchasing.
VFC	Vaccines for Children program. A federal program which makes vaccine available free in immunize children age 18 and under who are Medicaid eligible, who have no health insurance, who are native Americans or Alaskans, or who have health insurance but not for immunizations and receive their immunization at a FQHC.
Well Child Visits/EPSTD	Early and periodic screening, diagnosis, and treatment program. A child health program of prevention and treatment intended to ensure availability and accessibility of primary, preventive, and other necessary health care resources and to help Medicaid children and their families to effectively use these resources.



**SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS**

I-A PURPOSE

The State of Michigan, by the Department of Management and Budget (DMB), Office of Purchasing, hereby enters into a Contract with the Contractor identified in Section III-A for the Michigan Department of Community Health (DCH).

The purpose of this Contract is to obtain the services of the Contractor to provide Comprehensive Health Care Program (CHCP) Services for Medicaid beneficiaries (Beneficiaries) in the service area as described in Attachment B to this Contract. This is a unit price (Per Member Per Month [PMPM] Capitated Rate) Contract, see Attachment A. The term of the Contract shall be effective October 1, 2000 and continue to October 1, 2002. The Contract may be extended for no more than three(3) one year extensions after September 30, 2002.

I-B ISSUING OFFICE

This Contract is issued by DMB, Office of Purchasing (Office of Purchasing), for and on the behalf of DCH. Where actions are a combination of those of the Office of Purchasing and DCH, the authority will be known as the State.

The Office of Purchasing is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services describe herein.. The Office of Purchasing is the only office authorized to change, modify, amend, clarify, or otherwise alter the prices, specifications, terms, and conditions of this Contract. The OFFICE OF PURCHASING will remain the SOLE POINT OF CONTACT until such time as the Director of Purchasing shall direct otherwise in writing. See Paragraph I-C below. All communications with the DMB must be addressed to:

Ray Irvine
Office of Purchasing
Department of Management & Budget
P.O. Box 30026
Lansing, MI 48909

I-C CONTRACT ADMINISTRATOR

Upon receipt by the Office of Purchasing of the properly executed Contract, it is anticipated that the Director of Purchasing will direct that the person named below be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of the Contract. That authority is retained by the Office of Purchasing. The Contract Administrator for this project is:

Richard B. Murdock, Director
Comprehensive Health Plan Division
Medical Services Administration
Department of Community Health
P.O. Box 30479
Lansing, Michigan 48909



I-D TERM OF CONTRACT

The term of this Contract shall be from October 1, 2000 through September 30, 2002. The Contract may be extended for no more than three (3) one year extensions after September 30, 2002. The State's fiscal year is October 1st through September 30th. Payments in any given fiscal year are contingent upon and subject to enactment of legislative appropriations.

Because Beneficiaries must have a choice among Contractors, the State cannot guarantee an exact number of Enrollees to any Contractor.

I-E PRICE

Prices shall be held firm through September 30, 2001. Prices offered by the Contractor in the response to the RFP for the period October 1, 2001 through October 1, 2002 are subject to written acceptance by the Director of Purchasing. Price adjustments for this second year period of the Contract and for any Contract extension thereafter may be proposed by the State or the Contractor. Price adjustments proposed by the Contractor must be submitted in writing to the Director of Purchasing no later than June 15th of each contract year. Price adjustments proposed by the State will be submitted to the Contractor in no later than June 15th of each contract year.

Any changes requested by either party are subject to negotiation and written acceptance by the State Purchasing Director before becoming effective. In the event the State and the Contractor cannot agree to changes by August 31st of each contract year, the Contract may be canceled pursuant to Section I-O (6) CANCELLATION. The exact dollar value of this Contract is unknown; the Contractor will be paid based on actual Beneficiary enrollment at the rates (prices) specified in Attachment "A" (Awarded Prices) of the Contract.

I-F COST LIABILITY

The State assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this Contract by all parties. Total liability of the State is limited to the terms and conditions of this Contract.

I-G CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities relative to this Contract whether or not that Contractor performs them. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract. Although it is anticipated that the Contractor will perform the major portion of the duties as requested, subcontracting by the Contractor for performance of any of the functions requires prior notice to the State. The Contractor must identify all subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The Contractor must also outline the contractual relationship between the Contractor and each subcontractor. The State reserves the right to approve subcontractors for administrative functions for this project and to require the



Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

A subcontractor is any person or entity that performs a required, ongoing function of the Contractor under this Contract. A health care provider included in the network of the Contractor is not considered a subcontractor for purposes of this Contract unless otherwise specifically noted in this Contract. Contracts for one-time only functions or service contracts, such as maintenance or insurance protection, are not intended to be covered by this section.

Although Contractors may enter into subcontracts, all communications shall take place between the Contractor and the State directly; therefore, all communication by subcontractors must be with the Contractor only, not with the State.

If a Contractor elects to use a subcontractor not specified in the Contractor's response, the State must be provided with a written request at least 21 days prior to the use of such subcontractor. Use of a subcontractor not approved by the State may be cause for termination of the Contract.

In accordance with 42 CFR 434.6(b), all subcontracts entered into by the Contractor must be in writing and fulfill the requirements of 42 CFR 434.6(a) that are appropriate to the service or activity delegated under the subcontract. All subcontracts must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All subcontracts must fulfill the requirements of this Contract that are appropriate to the services or activities delegated under the subcontract. For each portion of the proposed services to be arranged for and administered by a subcontractor, the technical proposal must include: (1) the identification of the functions to be performed by the subcontractor, and (2) the subcontractor's related qualifications and experience. All employment agreements, provider contracts, or other arrangements by which the Contractor intends to deliver services required under this Contract, whether or not characterized as a subcontract, shall be subject to review and approval by the State and must meet all other requirements of this paragraph appropriate to the service or activity delegated under the agreement.

The Contractor shall furnish information to the State as to the amount of the subcontract, the qualifications of the subcontractor for guaranteeing performance, and any other data that may be required by the State. All subcontracts held by the Contractor shall be made available on request for inspection and examination by appropriate State officials, and such relationships must meet with the approval of the State.

The Contractor shall furnish information to the State necessary to administer all requirements of the Contract. The State shall give Contractors at least 30 days notice before requiring new information.

I-H NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No information or data related to this Contract is to be released without prior approval of the designated State personnel.



I-I DISCLOSURE

All information in this Contract is subject to the provisions of the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231, *et seq.*

I-J CONTRACT INVOICING AND PAYMENT

This Contract reflects a fixed reimbursement mechanism and the specific payment schedule for this Contract will be monthly. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. DCH will generate reports to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, DCH will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month. A process will be in place to ensure timely payments and to identify Enrollees that the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns).

The application of Contract remedies and performance bonus payments as described in Section II of this Contract will affect the lump sum payment. Payments in any given fiscal year are contingent upon and subject to enactment of legislative appropriations.

I-K ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted accounting principles and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the Health Care Financing Administration (HCFA), the State of Michigan, its designees, the Department of Attorney General, or the Office of Auditor General at any time during the Contract period and any extension thereof, and for six (6) years from expiration date and final payment on the Contract or extension thereof.

I-L INDEMNIFICATION

1. General Indemnification

The Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections, commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

- (a) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the products and services provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract;
- (b) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;



- (c) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or related to occurrences that the Contractor is required to insure against as provided for in this Contract;
- (d) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable;
- (e) any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

2. Patent/Copyright Infringement Indemnification

The Contractor shall indemnify, defend and hold harmless the State, its employees and agents from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorney's fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software, commodity or service infringes any United States of America or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States of America. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor shall at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to the Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

3. Indemnification Obligation Not Limited

In any and all claims against the State of Michigan, or any of its agents or employees, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.



4. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and effect notwithstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions that occurred prior to termination.

5. Exclusion

The Contractor is not required to indemnify the State of Michigan for services provided by health care providers mandated under federal statute or State policy, unless the health care provider is a voluntary contractual member of the Contractor's provider network. Local agreements with Community Mental Health Services program (CMHSP) do not constitute network provider contracts.

I-M CONTRACTOR'S LIABILITY INSURANCE

The Contractor shall purchase and maintain such insurance as will protect it from claims set forth below, which may arise out of or result from the Contractor's operations under the Contract whether such operations are by it or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:

- 1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other state the Contractor shall have insurance or participate in a mandatory State fund to cover the benefits payable to any such employee.

In the event any work is subcontracted, the Contractor shall require the subcontractor similarly to provide workers' compensation insurance for all the subcontractor's employees working in the State, unless those are covered by the workers' compensation protection afforded by the Contractor. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State.

- 2) Claims for damages because of bodily injury, occupational sickness or disease; or death of its employees.
- 3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than its employees, subject to limits of liability of not less than \$1,000,000.00 each occurrence and, when applicable, \$2,000,000.00 annual aggregate for non-automobile hazards and as required by law for automobile hazards.
- 4) Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than \$50,000.00 each occurrence for non-automobile hazards and as required by law for automobile hazards.
- 5) Insurance for subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than \$1,000,000.00 each occurrence and when applicable, \$2,000,000.00 annual aggregate.



- 6) Director's and Officer's Errors and Omissions coverage that includes coverage of the Contractor's peer review and care management activities and has limits of at least \$1,000,000.00 per occurrence and \$3,000,000.00 aggregate.
- 7) The Contractor shall also require that each of its subcontractors maintain insurance coverage as specified above, except for subparagraph (6), or have the subcontractors provide coverage for each subcontractor's liability and employees. The Contractor must provide proof, upon request of the DCH, of its Provider's medical professional liability insurance in amounts consistent with the community accepted standards for similar professionals. The provision of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its subcontractors herein.
- 8) The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract.
- 9) BEFORE STARTING WORK THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF PURCHASING, ORIGINAL CERTIFICATE(S) OF INSURANCE VERIFYING THAT THE REQUIRED LIABILITY COVERAGE IS IN EFFECT FOR THE AMOUNTS SPECIFIED IN THE CONTRACT. THE CONTRACT NUMBER MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ENSURE CORRECT FILING. The Contractor must immediately notify the State of any changes in type, amount, or duration of insurance coverage. These certificates shall contain a provision to the effect that the policy will not be canceled until at least fifteen days prior written notice has been given to the State. The written notice will have the Contract number and must be received by the Director of Purchasing.

I-N LITIGATION

The State, its departments, and its agents shall not be responsible for representing or defending the Contractor, Contractor's personnel, or any other employee, agent or subcontractor of the Contractor, named as a defendant in any lawsuit or in connection with any tort claim.

The State and the Contractor agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or persons not a party to the Contract.

The Contractor shall submit annual litigation reports in a format established by DCH, providing the following detail for all civil litigation that the Contractor, subcontractor, or the Contractor's insurers or insurance agents are parties to:

- Case name and docket number
- Name of plaintiff(s) and defendant(s)
- Names and addresses of all counsel appearing
- Nature of the claim
- Status of the case.

The provisions of this section shall survive the expiration or termination of the Contract.



I-O CANCELLATION

- 1) The State may cancel the Contract for default of the Contractor. Default is defined as the failure of the Contractor to fulfill the obligations of the proposal or Contract. In case of default by the Contractor, the State may immediately cancel the Contract without further liability to the State, its departments, agencies, and employees, and procure the articles or services from other sources, and hold the Contractor responsible for all costs occasioned thereby.
- 2) The State may cancel the Contract in the event the State no longer needs the services or products specified in the Contract, or in the event program changes, changes in laws, rules or regulations occur. The State may cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees by giving the Contractor written notice of such cancellation 30 days prior to the date of cancellation.
- 3) The State may cancel the Contract for lack of funding. The Contractor acknowledges that the term of this Contract extends for several fiscal years and that continuation of this Contract is subject to appropriation of funds for this project. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State shall have the right to terminate this Contract without penalty at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to the Contractor. The State shall give the Contractor written notice of such non-appropriation within 30 days after it receives notice of such non-appropriation.
- 4) The State may immediately cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees if the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public, or private contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under state or federal antitrust statutes; or convicted of any other criminal offense, which, in the sole discretion of the State, reflects poorly on the Contractor's business integrity.
- 5) The State may immediately cancel the Contract in whole or in part by giving notice of termination to the Contractor if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, Section 5, and Civil Service Rule 4-6.
- 6) The State may, with 30 days written notice to the Contractor, cancel the Contract in the event prices proposed for Contract modification/extension are unacceptable to the State. (See Sections I-E, Price, and I-T, Modification of Contract).
- 7) Either the State or the Contractor may, upon 90 days written notice, cancel the contract for the convenience of either party.

In the event that a Contract is canceled, the Contractor will cooperate with the State to implement a transition plan for Enrollees. The Contractor will be paid for Covered Services provided during the transition period in accordance with the Capitation Rates in effect between the Contractor and the State at the time of cancellation. Contractors will be provided due process before the termination of any Contract.



I-P ASSIGNMENT

The Contractor shall not have the right to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State Purchasing Director. To obtain consent for assignment of this Contract to another party, documentation must be provided to the State Purchasing Director to demonstrate that the proposed assignee meets all of the requirements for a Contractor under this Contract. Any purported assignment in violation of this Section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without consent of the Director of Purchasing.

I-Q DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.

I-R CONFIDENTIALITY

The use or disclosure of information regarding Enrollees obtained in connection with the performance of this Contract shall be restricted to purposes directly related to the administration of services required under the Contract.

I-S NON-DISCRIMINATION CLAUSE

The Contractor shall comply with the Elliott-Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2101 *et seq.*, the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 *et seq.*, and all other federal, state and local fair employment practices and equal opportunity laws and covenants that it shall not discriminate against any employee or applicant for employment, to be employed in the performance of this Contract, with respect to his or her hire, tenure, terms, conditions, or privileges of employment, or any matter directly or indirectly related to employment, because of his or her race, religion, color, national origin, age, sex, height, weight, marital status, or physical or mental disability that is unrelated to the individual's ability to perform the duties of a particular job or position. The Contractor agrees to include in every subcontract entered into for the performance of this Contract this covenant not to discriminate in employment. A breach of this covenant is a material breach of this Contract.

I-T MODIFICATION OF CONTRACT

The Director of Purchasing reserves the right to modify Covered Services required under this Contract during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary. Any changes in pricing proposed by the Contractor resulting from the requested changes are subject to acceptance by the State. Changes may be increases or decreases. Contract changes will not be necessary in order for the Contractor to keep current with changes in the delivery of Covered Services that may result from new technology or new drugs.

IN THE EVENT PRICES SUBMITTED AS THE RESULT OF A MODIFICATION OF COVERED SERVICE ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT MAY BE TERMINATED AND THE CONTRACT MAY BE SUBJECT TO COMPETITIVE



BIDDING AND AWARD BASED UPON THE NEW MODIFIED COVERED SERVICES IF ADEQUATE CAPACITY IS NOT READILY AVAILABLE TO SERVE BENEFICIARIES IN THE AFFECTED SERVICE AREA THROUGH EXISTING CONTRACTS WITH OTHER CONTRACTORS.

I-U ACCEPTANCE OF PROPOSAL CONTENT

The contents of the RFP and the Contractor's proposal resulting in this Contract are contractual obligations.

I-V RIGHT TO NEGOTIATE EXPANSION

The State reserves the right to negotiate expansion of the services outlined within this Contract to accommodate the related service needs of additional selected State agencies, or of additional entities within DCH.

Such expansion shall be limited to those situations approved and negotiated by the Office of Purchasing at the request of DCH or another State agency. The Contractor shall be obliged to expeditiously evaluate and respond to specified needs submitted by the Office of Purchasing with a proposal outlining requested services and pricing. All pricing for expanded services shall be shown to be consistent with the cost elements and /or unit pricing of the original Contract.

In the event that a Contract expansion proposal is accepted by the State, the Office of Purchasing shall issue a Contract change notice to the Contractor as notice to the Contractor to provide the work specified. Compensation is not allowed the Contractor until such time as a Contract change notice is issued.

I-W MODIFICATIONS, CONSENTS AND APPROVALS

This Contract will not be modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

I-X ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

The following documents constitute the complete and exclusive statement of the agreement between the parties as it relates to this transaction. In the event of any conflict among the documents making up the Contract, the following order of precedence shall apply (in descending order of precedence):

- A. This Contract and any Addenda thereto
- B. State's RFP and any Addenda thereto
- C. Contractor's proposal to the State's RFP and Addenda
- D. Policy manuals of the Medical Assistance Program and subsequent publications

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the State and those indicated by the Contractor, those of the State take precedence.

This Contract supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties.



I-Y NO WAIVER OF DEFAULT

The failure of the State to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the State of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-Z SEVERABILITY

Each provision of this Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-AA DISCLAIMER

All statistical and fiscal information contained within the Contract and its attachments, and any amendments and modifications thereto, reflect the best and most accurate information available to DCH at the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages, either real or punitive.

Captions and headings used in this Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-BB RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

The relationship between the State and the Contractor is that of client and independent contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be deemed to be an employee, agent or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants, and subcontractors during the performance of a contract resulting from this Contract.

I-CC NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party at the address indicated in sections I-B, I-C and III-A of this Contract upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by telefacsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Either party may change its address where notices are to be sent by giving written notice in accordance with this Section.

I-DD UNFAIR LABOR PRACTICES

Pursuant to 1980 PA 278, as amended, MCL 423.321 *et seq.*, the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Consumer and Industry Services. The State may void any contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the contractor appears in the register.

I-EE SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to, the Contractor's indemnity and other obligations, shall survive the expiration or cancellation of this Contract for any reason.

I-FF GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan.

I-GG YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that all software which the Contractor either sells or licenses to the State of Michigan and used by the State prior to, during or after the calendar year 2000, includes or shall include, at no added cost to the State, design and performance so the State shall not experience software abnormality and/or the generation of incorrect results from the software, due to date oriented processing, in the operation of the business of the State of Michigan.

The software design, to insure year 2000 compatibility, shall include, but is not limited to: data structures (databases, data files, etc.) that provide 4-digit date century; stored data that contain date century recognition, including, but not limited to, data stores in databases and hardware device internal system dates; calculations and program logic (e.g., sort algorithms, calendar generation, event recognition, and all processing actions that use or produce date values) that accommodates same century and multi-century formulas and date values; interfaces that supply data to and receive data from other systems or organizations that prevent non-compliant dates and data from entering any State system; user interfaces (i.e., screens, reports, etc.) that accurately show 4 digit years; and assurance that the year 2000 shall be correctly treated as a leap year within all calculation and calendar logic.

SECTION II WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

1. Value Purchasing

The creation of DCH through Executive Order 1996-1 brought together policy, programs and resources to enable the State to become a more effective purchaser of health care services for the Medicaid population. As the single State agency responsible for health policy and purchasing of health care services using State appropriated and federal matching funds, DCH intends to get better value while ensuring quality and access. DCH will focus on "value purchasing". Value purchasing involves aligning financing incentives to stimulate appropriate changes in the health delivery system that will:

- bring organization and accountability for the full range of benefits,
- provide greater flexibility in the range of services;
- improve access to and quality of care;
- achieve greater cost efficiency; and
- link performance of Contractors to improvements in the health status of the community.

2. Managed Care Direction

Under the Comprehensive Health Care Program (CHCP), the State selectively contracts with Contractors who will accept financial risk for managing comprehensive care through a performance contract. The managed care direction is the health care purchasing direction for Michigan's future. Change in health care delivery systems is happening at the national and state levels. Michigan will proactively work to shape the health care marketplace as a purchaser of services. The focus will be on quality of care, accessibility, and cost-effectiveness.

It is critical that Michigan act now to bring the rate of growth in Medicaid more in line with the forecasted rate of growth in State revenues. Since 1990, State revenues have grown by about 3% per year. The growth of the Medicaid budget must be slowed but, at the same time, access to quality health care for the Medicaid population must be ensured.

There are three basic ways to slow down cost growth: restrict eligibility, reduce benefits, or stimulate more efficiency in the health delivery system through managed care. DCH has chosen not to make program cuts, but rather to use the efficiency approach because other important health care goals can be achieved at the same time.

There are two categories of specialized services that are available outside of the CHCP. These are behavioral health services and services for persons with developmental disabilities. These specialized services are clearly defined as beyond the scope of benefits that are included in the CHCP. Any Contractor contracting with the State as a capitated managed care provider will be responsible for coordinating access to these specialized services with those providers designated by the State to provide them. The criteria for contracted Qualified Health Plans (QHPs) include the implementation of local agreements with the behavioral health and developmental disability providers who are under



contract with DCH. Model agreements between Contractors and behavioral health and developmental disability providers are included in the appendix to this Contract.

II-B OBJECTIVES

1. Objectives

The Contract objectives of the State are:

- the assurance of access to primary and preventive care;
- the coordination for all necessary health care services;
- the provision of medical care that is of high quality, provides continuity and is appropriate for the individual; and
- the delivery of health care in a manner that makes costs more predictable for the Medicaid population.

2. Objectives for Special Needs

When providing services under the CHCP; the Contractor must take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population in the CHCP. As an objective, the Contractor must also stress the collaborative effort of both the State and the private sector to operate a managed care system that meets the special needs of these Enrollees.

It is recognized that special needs will vary by individual and by county or region. Contractors must have an underlying organizational capacity to address the special needs of their Enrollees, such as: responding to requests for assignment of specialists as Primary Care Providers (PCP), assisting in coordinating with other support services, and generally responding and anticipating needs of Enrollees with special needs. Under their Covered Service responsibilities, Contractors are expected to provide early prevention and intervention services for recipients with special needs, as well as all other recipients.

As an example, while support services for persons with developmental disabilities may be outside of the direct service responsibility of the Contractor, the Contractor does have responsibility to assist in coordinating arrangements to receive necessary support services. This coordination must be consistent with the person-centered planning principles established within the revised Michigan's Mental Health Code.

Another example would be for Enrollees who have chronic illnesses such as diabetes or end-stage renal disease. In these instances, the PCP assignment may be more appropriately located with a specialist within the Contractor's network. When a Contractor designates a physician specialist as the PCP, that PCP will be responsible for coordinating all continuing medical care for the assigned Enrollee.

3. Objectives for Contractor Accountability

Contractor accountability must be established in order to ensure that the State's objectives for managed care and goal for immunizations are met and the objectives for special populations are addressed. Contractors contracting with the State will be held accountable for:

- Ensuring that all Covered Services are available and accessible to Enrollees with reasonable promptness and in a manner which ensures continuity.



- Medically necessary services shall be available and accessible 24 hours a day and 7 days a week.
- Delivering health care services in a manner that focuses on health promotion and disease prevention and features disease management strategies.
 - Demonstrating the Contractor's capacity to adequately serve the Contractor's expected enrollment of Enrollees.
 - Providing access to appropriate providers, including qualified specialists for all medically necessary services including those specialists described under model agreements for behavioral health and developmental disabilities.
 - Providing assurances that it will not deny enrollment to, expel, or refuse to re-enroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of such assurances at the time of enrollment.
 - Paying providers in a timely manner for all Covered Services.
 - Establishing an ongoing internal quality improvement and utilization review program.
 - Providing procedures to ensure program integrity through the detection and elimination of fraud and abuse and cooperate with DCH and the Department of Attorney General as necessary.
 - Reporting encounter data and aggregate data including data on inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by the Department.
 - Providing procedures for hearing and timely resolving grievances between the Contractor and Enrollees.
 - Providing for outreach and care coordination to Enrollees to assist them in using their health care resources appropriately.
 - Collaborating, through local agreements, with specialized behavioral and developmental disability services contractors on services provided by them to the Contractor's Enrollees.
 - Providing assurances for the Contractor's solvency and guaranteeing that Enrollees and the State will not be liable for debts of the Contractor.
 - Meeting all standards and requirements contained in this Contract, and complying with all applicable federal and state laws, administrative rules, and policies promulgated by DCH.
 - Cooperating with the State and/or HCFA in all matters related to fulfilling Contract requirements and obligations.

II-C SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the Contractor must meet and the services that must be provided under the Contract. The Contractor is not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the CHCP.

II-D TARGETED GEOGRAPHICAL AREA FOR IMPLEMENTATION OF THE CHCP

1. Regions

The State will divide the delivery of Covered Services into ten regions.

Contractor's plans for Region 1 and 10 must be tailored to each county in terms of the provider network, Enrollment Capacity and Capitation Rates. Region 1 (Wayne County) and Region 10 (Oakland County) may have partial county service areas.

Contractor's plans for Regions 2 through 9 must establish:

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

November 7, 2001

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B1001038
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
Contract Administrator: Rick Murdock Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health		BUYER (517) 246-2647 Irene Pena 
CONTRACT PERIOD:		From: October 1, 2000 To: October 1, 2002*
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

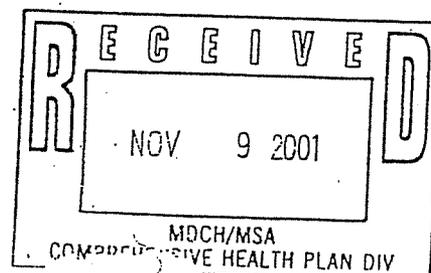
Effective 10/1/01 the attached document is hereby incorporated into this contract.

AUTHORITY/REASON:

Per agency's request from Rick Murdock on 9/27/01 and in accordance with the modification clause

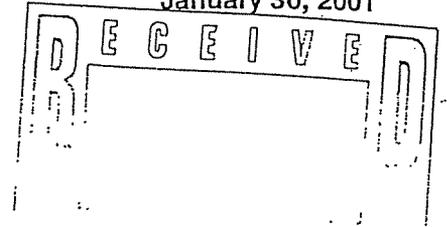
TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.



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

January 30, 2001



CHANGE NOTICE NO. 1

TO

CONTRACT NO. 071B1001038

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
Contract Administrator: Rick Murdock Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health		BUYER (517) 373-2467 Ray E. Irvine, C.P.M.
CONTRACT PERIOD: From: October 1, 2000		To: October 1, 2002*
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

The attached three (3) pages of Contract Changes are effective February 1, 2001. A revised contract document incorporating these changes will be distributed by Department of Community Health (DCH) (Mr. Rick Murdock's office) at a later date.

AUTHORITY/REASON:

Request of agency per memo from Rick Murdock dated 1-17-01, and Section I-T (Modification of Contract)

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

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

April 19, 2002

CHANGE NOTICE NO. 4
 TO
 CONTRACT NO. 071B1001038
 between
 THE STATE OF MICHIGAN
 and

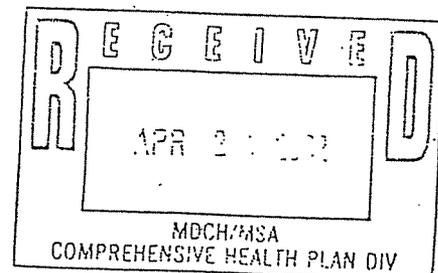
NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (067)
		BUYER (517) 241-1647 Irene Pena <i>[Signature]</i>
Contract Administrator: Rick Murdock Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health		
CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2003		
TERMS N/A	SHIPMENT N/A	
F.O.B. N/A	SHIPPED FROM N/A	
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

Effective immediately this contract is hereby EXTENDED through 10/1/03 per the extension clause of the contract.

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.





ALL STATE LEGAL 800-222-0510 ED11 RECYCLED

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

April 30, 2002

CHANGE NOTICE NO. 5
 TO
 CONTRACT NO. 071B1001038
 between
 THE STATE OF MICHIGAN
 and

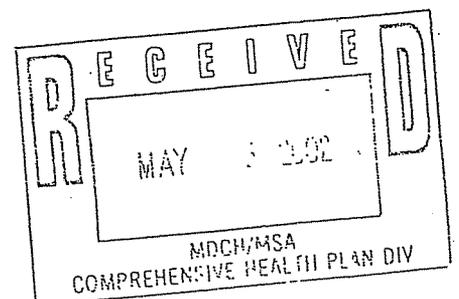
NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
		BUYER (517) 241-1647 Irene Pena <i>[Signature]</i>
		Contract Administrator: Rick Murdock Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health
CONTRACT PERIOD:		From: October 1, 2000 To: October 1, 2004
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

Effective immediately, the attached list of changes are hereby incorporated into this contract per agency request from Rick Murdock.

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.



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

December 18, 2002

RECEIVED
 DEC 23 2002
 MSA/CHPD

CHANGE NOTICE NO. 6

TO

CONTRACT NO. 071B1001038

between

**THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
Contract Administrator: Cheryl Bupp Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health		BUYER (517) 241-1647 Irene Pena <i>[Signature]</i>
CONTRACT PERIOD: From: October 1, 2000		To: October 1, 2004
TERMS N/A	SHIPMENT N/A	
F.O.B. N/A	SHIPPED FROM N/A	
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

Effective 10/01/02, the attached amendment is hereby incorporated into this contract.

AUTHORITY/REASON (S):

Per agency's request by Cheryl Bupp on 10/28/02 and DMB/Acquisition Services.

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JOHN ENGLER
GOVERNOR

JAMES K. HAVEMAN, JR.
DIRECTOR

Return correspondence to:
PO Box 30479
Lansing, MI 48909-7979

MEMORANDUM

Date: October 28, 2002

To: Irene Pena
DMB Office of Purchasing

From: Cheryl Bupp, Manager *Cheryl Bupp*
Plan Management Section

Subject: Recommended Contract Change Notices for Medicaid Health Plans

The attached document contains 14 proposed contract changes to our current contract with Medicaid Health Plans. These changes are needed to become compliant with the Code of Federal Regulations signed in August of 2002. The state has until August of 2003 to become fully compliant with these regulations, however, these changes are necessary now. The effective date of these changes will be October 1, 2002.

The proposed changes were discussed in detail at a special contract meeting with all of the Health Plans on August 27, 2002 and again at the Health Plan Administrative meeting held with all contracting plans on September 24, 2002. Health Plan concerns have been taken into account in the final drafting of the contract change.

I am hopeful that you will be able to process these changes as soon as possible. Please contact my office if you have any questions.

cc: Susan Moran
Sheila Embry

MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2002 – September 30, 2003)

ATTACHMENT D – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. The performance monitoring standards are intended to be part of the Contract between the State of Michigan and Contracting Health Plans (Attachment D).

The process is intended to be dynamic and reflect statewide issues that may change on a year to year basis. Performance measurement will be shared with Health Plans during the fiscal year that will compare performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address reflect the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Encounter Data
- Provider File reporting
- Claims Payment

Within each area, specific performance measures will be identified including:

- Goals description
- Minimum Performance Standard for each measure
- Data Source
- Monitoring Intervals, (monthly, quarterly, annually) to be used by DCH

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract section II-W.

PERFORMANCE AREA	GOAL DESCRIPTION	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> Quality of Care: Childhood Immunization 	Fully immunize children who turn two years old during the calendar year.	Combination 1 *Rate ≥ 50%	HEDIS report	Annual
<ul style="list-style-type: none"> Quality of Care: Prenatal care 	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	** ≥ 55%	HEDIS report	Annual
<ul style="list-style-type: none"> Access to care: Well child visits 0-15 months 	Children 0-15 months of age receive one or more well child visits during 12 month period	≥ 90%	Encounter data	Quarterly (rolling 12 months)
<ul style="list-style-type: none"> Access to care: Well child visits 3-6 years 	Children three, four, five, and six old receive one or more well child visits during twelve month period.	≥ 45%	Encounter data	Quarterly (rolling 12 months)
<ul style="list-style-type: none"> Claims Reporting 	Health Plans are compliant with statutory requirements for payment of clean claims within 45 days	100 %	Claims report submitted by health plan	Monthly
<ul style="list-style-type: none"> Customer Services: Enrollee complaints 	Plans will have minimal enrollee contacts through Medicaid Helpline which are determined to be a complaint issue	complaint rate < 5 per 1000 members per month	Beneficiary/Provider complaint tracking (BPCT)	Monthly
<ul style="list-style-type: none"> Encounter data reporting 	Timely and complete encounter data submission by the 15th of the month	100%	MDCH Data Exchange Gateway (DEG)	Monthly
<ul style="list-style-type: none"> Provider File Reporting 	Timely provider file submission by the 1st of the month	100%	MI Enrolls	Monthly

Minimum Standard = * ≥ 50, October 1, 2002 – June 30, 2003, ≥ 65, July 1, 2003 – September 30, 2003 with release of HEDIS 2003 report.
 ** ≥ 55, October 1, 2002 - January 30, 2003, ≥ 65, February 1, 2003 - September 30, 2003

Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 17110000251

Proposed Contract Change No. 1:

Amend Section I-E (Price) by eliminating the first 2 sentences of the first paragraph and replacing "this" with "the" in the third sentence.

Amend Section I-E (Price) by adding the following paragraph describing the Quality Assurance Assessment Program.

Consistent with Public Act 304 of 2002 and with the approval from The Center for Medicare and Medicaid Services, the Quality Assurance Assessment Program will allow the Michigan Department of Community Health to quarterly assess a fee on the non-Medicare premiums of each HMO that has a Medicaid Contract. From that revenue, the rates for each health plan will be adjusted quarterly based on the mix of contracting health plans during each quarter and the number of Medicaid enrollees during that quarter. Penalties are established in Public Act 304 for failure to pay the assessment. Attachment A (Awarded Prices) of the current contract will be amended quarterly to reflect the revised rates.

Rationale: Public Act 304 requires the Department to develop and implement the Quality Assurance Assessment Program. Therefore, the contract amendment is requested to comply with this law.

Proposed Contract Change No. 2:

Replace Section II-G-4 (Rural Area Exception) with language consistent with the final BBA rules signed on 6/13/02 and the amendment to the waiver sought by DCH.

The DCH will establish a Rural Exception Policy consistent with 42 CFR 438.52 and with the approval from The Center for Medicare and Medicaid Services that permits a rural exception to the waiver requirement of having two HMOs in every county. This exception will permit mandatory enrollment of beneficiaries into a single health plan. This policy will only be implemented in counties that are designated as "Rural." A Rural County is defined as any county that is non-urban.

The beneficiary must be permitted to choose from at least two physicians or case managers. The beneficiary must have the option of obtaining services from any other provider if the following conditions exist:

- A. The type of service or specialist is not available within the HMO,
- B. The provider is not part of the network, but is the main source of a service to the beneficiary,
- C. The only provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks,
- D. Related services must be performed by the same provider and all of the services are not available within network,
- E. The State determines other circumstances that warrant out of network treatment.



ALL-STATE® LEGAL 800-222-0510 ED11 RECYCLED

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

August 1, 2003

CHANGE NOTICE NO. 7
 TO
 CONTRACT NO. 071B1001038
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE Gregory H. Moses (313) 393-4570
OmniCare Health Plan Gregory H. Moses, Jr., President & CEO 1155 Brewery Park Blvd., Suite 250 Detroit, MI 48207		VENDOR NUMBER/MAIL CODE (2) 38-2031377 (007)
		BUYER (517) 241-1647 Irene Pena <i>[Signature]</i>
		Contract Administrator: Cheryl Bupp Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health
CONTRACT PERIOD: From: October 1, 2000		To: October 1, 2004
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS *Plus three (3) each possible one-year extensions		

NATURE OF CHANGE (S):

Effective August 1, 2003, the attached revisions are hereby incorporated into the contract.

AUTHORITY/REASON (S):

Per agency request by Cheryl Bupp on 7/01/03 and DMB/ACQUISITION SERVICES.

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

RECEIVED

MAY 17 2004



MSA/MCPD HEALTH QUARTERLY STATEMENT AS OF March 31, 2004 OF THE CONDITION AND AFFAIRS OF THE OmniCare Health Plan

NAIC Group Code 0000 (Current Period) 0000 (Prior Period) NAIC Company Code 85582 Employer's ID Number 38-2031377
Organized under the Laws of Michigan State of Domicile or Port of Entry Michigan
Country of Domicile United States of America
Licenses as business type: Life, Accident & Health [] Dental Service Corporation [] Other [] Property/Casualty [] Vision Service Corporation [] la HMO Federally Qualified? Yes[X] No [] Hospital, Medical & Dental Services or Indemnity [] Health Maintenance Organization[X]
Date Commenced Business 09/23/1972 12/23/1973
Statutory Home Office 1155 Brewery Park, Suite 250 Detroit, MI 48207
Main Administrative Office 1155 Brewery Park, Suite 250 Detroit, MI 48207
Mail Address 1155 Brewery Park, Suite 250 Detroit, MI 48207
Primary Location of Books and Records 1155 Brewery Park, Suite 250 Detroit, MI 48207
Internal Website Address WWW.ochp.com
Statutory Statement Contact Kanyata J. Rogers, Controller (313)393-2379
Policyowner Relations Contact Krogars@ochp.com (313)393-4743

OFFICERS

Bobby L. Jones, Deputy Rehabilitator
Beverly Allen, Deputy Rehabilitator

OTHERS

DIRECTORS OR TRUSTEES

Herman B. Gray M.D.
Tel Martoo M.D.

George Shado M.D.

State of Michigan
County of Wayne ss

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and that the income and deductions therefrom for the period ended, and have been computed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manuals, except to the extent that: (1) state law may differ, or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their independent knowledge and belief, respectively. Furthermore, the scope of this declaration by the described officers also includes the related corresponding electronic filing with the NAIC, when required, but is not an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Signatures of Bobby Jones, Beverly Allen, and Treasurer. Includes printed names and titles.

Subscribed and sworn to before me this 14th day of May, 2004

a. Is this an original filing?
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

Yes[X] No []

Notary Public Signature of Rochelle D. Jenkins

ROCHELLE D. JENKINS
NOTARY PUBLIC - WAYNE COUNTY, MI
MY COMMISSION EXPIRES 12/25/06

ASSETS

	Current Statement Date			4 December 31, Prior Year Net Admitted Assets
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	
1. Bonds	1,214,260		1,214,260	1,079,334
2. Stocks:				
2.1 Preferred stocks				
2.2 Common stocks	(26,973)		(26,973)	(61,908)
3. Mortgage loans on real estate:				
3.1 First liens				
3.2 Other than first liens				
4. Real estate:				
4.1 Properties occupied by the company (less \$..... encumbrances)				
4.2 Properties held for the production of income (less \$..... encumbrances)				
4.3 Properties held for sale (less \$..... encumbrances)				
5. Cash (\$.....3,429,367), cash equivalents (\$.....111,447) and short-term investments \$.....0	3,540,814		3,540,814	5,283,074
6. Contract loans (including \$..... premium notes)				
7. Other invested assets				
8. Receivable for securities				
9. Aggregate write-ins for invested assets				
10. Subtotals, cash and invested assets (Lines 1 to 9)	4,726,101		4,726,101	6,280,500
11. Investment income due and accrued	11,953		11,953	14,224
12. Premiums and considerations:				
12.1 Uncollected premiums and agents' balances in the course of collection	1,828,282	3,627	1,824,655	2,828,031
12.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$..... earned but unbilled premiums)				
12.3 Accrued retrospective premiums				
13. Reinsurance:				
13.1 Amounts recoverable from reinsurers				
13.2 Funds held by or deposited with reinsured companies				
13.3 Other amounts receivable under reinsurance contracts				
14. Amounts receivable relating to uninsured plans				
15.1 Current federal and foreign income tax recoverable and interest thereon ..				
15.2 Net deferred tax asset				
16. Guaranty funds receivable or on deposit				
17. Electronic data processing equipment and software	264,659	264,659		0
18. Furniture and equipment, including health care delivery assets (\$.....)				
19. Net adjustments in assets and liabilities due to foreign exchange rates ..				
20. Receivables from parent, subsidiaries and affiliates				892,937
21. Health care (\$.....2,930,170) and other amounts receivable	5,193,421	2,150,000	3,043,421	1,994,340
22. Other assets nonadmitted				
23. Aggregate write-ins for other than invested assets				
24. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 10 to 23)	12,024,416	2,418,266	9,606,130	12,110,032
25. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
26. TOTALS (Lines 24 and 25)	12,024,416	2,418,266	9,606,130	12,110,032
DETAILS OF WRITE-INS				
0901				
0902				
0903				
0906. Summary of remaining write-ins for Line 9 from overflow page				
0999. TOTALS (Lines 0901 through 0903 plus 0906) (Line 9 above)				
2301				
2302				
2303				
2306. Summary of remaining write-ins for Line 23 from overflow page				
2399. TOTALS (Lines 2301 through 2303 plus 2306) (Line 23 above)				

LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$..... reinsurance ceded)	17,767,779	205,748	17,973,527	20,735,083
2. Assured medical incentive pool and bonus amounts	1,075,374		1,075,374	669,646
3. Unpaid claims adjustment expenses	174,202		174,202	164,628
4. Aggregate health policy reserves				
5. Aggregate life policy reserves				
6. Property/casualty unearned premium reserve				
7. Aggregate health claim reserves				
8. Premiums received in advance				
9. General expenses due or accrued	2,690,441		2,690,441	2,853,210
10.1 Current federal and foreign income tax payable and interest thereon (including \$..... on realized gains (losses))				
10.2 Net deferred tax liability				
11. Ceded reinsurance premiums payable				
12. Amounts withheld or retained for the account of others				
13. Remittances and items not allocated				
14. Borrowed money (including \$..... current) and interest thereon \$..... (including \$..... current)				
15. Amounts due to parent, subsidiaries and affiliates	64,116		64,116	
16. Payable for securities				
17. Funds held under reinsurance treaties with (\$..... authorized reinsurers and \$..... unauthorized reinsurers)				
18. Reinsurances in unauthorized companies				
19. Net adjustments in assets and liabilities due to foreign exchange rates				
20. Liability for amounts held under uninsured accident and health plans				
21. Aggregate write-ins for other liabilities (including \$..... current)				
22. Total liabilities (Lines 1 to 21)	21,771,912	205,748	21,977,660	24,622,667
23. Common capital stock	XXX	XXX		
24. Preferred capital stock	XXX	XXX		
25. Gross paid in and contributed surplus	XXX	XXX		
26. Surplus notes	XXX	XXX	13,977,132	13,977,132
27. Aggregate write-ins for other than special surplus funds	XXX	XXX		
28. Unassigned funds (surplus)	XXX	XXX	(26,348,662)	(26,489,667)
29. Less treasury stock, at cost:				
29.1 shares common (value included in Line 23 \$.....)	XXX	XXX		
29.2 shares preferred (value included in Line 24 \$.....)	XXX	XXX		
30. Total capital and surplus (Lines 23 to 28 minus Line 29)	XXX	XXX	(12,371,530)	(12,512,535)
31. Total liabilities, capital and surplus (Lines 22 and 30)	XXX	XXX	9,606,130	12,110,032
DETAILS OF WRITE-INS				
2101. Accrued Liabilities - FEMBP				
2102				
2103				
2198. Summary of remaining write-ins for Line 21 from overflow page				
2199. TOTALS (Lines 2101 through 2103 plus 2198) (Line 21 above)				
2701	XXX	XXX		
2702	XXX	XXX		
2703	XXX	XXX		
2798. Summary of remaining write-ins for Line 27 from overflow page	XXX	XXX		
2799. TOTALS (Lines 2701 through 2703 plus 2798) (Line 27 above)	XXX	XXX		

STATEMENT OF REVENUE AND EXPENSES

	Current Year To Date		Prior Year To Date
	1 Uncovered	2 Total	3 Total
1. Member Months	XXX	229,455	231,834
2. Net premium income (Including \$ non-health premium income)	XXX	44,637,072	40,507,843
3. Change in unearned premium reserves and reserves for rate credits	XXX		
4. Fee-for-service (net of \$ medical expenses)	XXX		
5. Risk revenue	XXX		
6. Aggregate write-ins for other health care related revenues	XXX	(2,557,397)	43,021
7. Aggregate write-ins for other non-health revenues	XXX		
8. Total revenues (Lines 2 to 7)	XXX	42,079,674	40,550,664
Hospital and Medical:			
9. Hospital/medical benefits	87,054	24,986,987	26,151,748
10. Other professional services		1,781,331	
11. Outside referrals			
12. Emergency room and out-of-area	41,245	3,757,531	4,681,872
13. Prescription drugs		7,614,438	6,356,775
14. Aggregate write-ins for other hospital and medical			
15. Incentive pool, withhold adjustments and bonus amounts		85,327	(888,544)
16. Subtotal (Lines 9 to 15)	138,309	38,215,615	36,501,651
Less:			
17. Net reinsurance recoveries			
18. Total hospital and medical (Lines 16 minus 17)	138,309	38,215,615	36,501,651
19. Non-health claims			
20. Claims adjustment expenses, including \$ cost containment expenses		340,773	485,207
21. General administrative expenses		3,522,622	3,426,314
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only)			
23. Total underwriting deductions (Lines 18 through 22)	138,309	42,079,010	40,365,172
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	665	185,692
25. Net investment income earned		23,428	30,850
26. Net realized capital gains (losses)			
27. Net investment gains or (losses) (Lines 25 plus 26)		23,428	30,850
28. Net gain or (loss) from agents' or premium balances charged off ((amount recovered \$ (amount charged off \$))			
29. Aggregate write-ins for other income or expenses		51	3,614
30. Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	24,144	220,156
31. Federal and foreign income taxes incurred	XXX		
32. Net income (loss) (Lines 30 minus 31)	XXX	24,144	220,156
DETAILS OF WRITE-INS			
0601. Quality Assessment Assurance Fee	XXX	(2,603,948)	
0602. Women, Infants, and Children Program Revenue	XXX	46,549	43,021
0603. Summary of remaining write-ins for Line 6 from overflow page	XXX		
0699. TOTALS (Lines 0601 through 0603 plus 0699) (Line 6 above)	XXX	(2,557,397)	43,021
0701. Summary of remaining write-ins for Line 7 from overflow page	XXX		
0702. Summary of remaining write-ins for Line 7 from overflow page	XXX		
0799. TOTALS (Lines 0701 through 0703 plus 0799) (Line 7 above)	XXX		
1401. Summary of remaining write-ins for Line 14 from overflow page	XXX		
1402. Summary of remaining write-ins for Line 14 from overflow page	XXX		
1499. TOTALS (Lines 1401 through 1403 plus 1499) (Line 14 above)	XXX		
2901. Miscellaneous income		51	3,614
2902. Summary of remaining write-ins for Line 29 from overflow page			
2999. TOTALS (Lines 2901 through 2903 plus 2999) (Line 29 above)		51	3,614

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year To Date	2 Prior Year
CAPITAL & SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year	(12,512,533)	(14,010,818)
GAINS AND LOSSES TO CAPITAL & SURPLUS		
34. Net income or (loss) from Line 32	24,144	220,155
35. Change in valuation basis of aggregate policy and claim reserves		
36. Net unrealized capital gains and losses	52,935	266,848
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax		
39. Change in nonadmitted assets	63,924	97,171
40. Change in unauthorized reinsurance		
41. Changes in treasury stock		
42. Change in surplus notes		2,268
43. Cumulative effect of changes in accounting principles		
44. Capital Changes:		
44.1 Paid in		
44.2 Transferred from surplus (Stock Dividend)		
44.3 Transferred to surplus		
45. Surplus adjustments:		
45.1 Paid in		
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus		(2,096)
48. Net change in capital and surplus (Lines 34 to 47)	141,003	584,347
49. Capital and surplus end of reporting period (Line 33 plus 48)	(12,371,530)	(13,426,471)
DETAILS OF WRITE-INS		
4701. Effect of Rehabilitation - reduction in liabilities		(2,096)
4702		
4703		
4799. Summary of remaining write-ins for Line 47 from overflow page		
4799. TOTALS (Lines 4701 through 4703 plus 4799) (Line 47 above)		(2,096)

CASH FLOW

		1 Current Year To Date	2 Prior Year Ended December 31
Cash from Operations			
1.	Premiums collected net of reinsurance	45,227,202	171,509,513
2.	Net investment income	15,358	106,284
3.	Miscellaneous income	(2,588,558)	(3,760,825)
4.	Total (Lines 1 through 3)	42,654,002	167,854,972
5.	Benefit and loss related payments	40,771,438	152,871,525
6.	Net transfers to Separate, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	3,488,684	12,980,916
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) \$..... net of tax on capital gains (losses)		
10.	Total (Lines 5 through 9)	44,260,122	165,852,441
11.	Net cash from operations (Line 4 minus Line 10)	(1,606,120)	2,002,531
Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:		
12.1	Bonds	75,000	363,325
12.2	Stocks		
12.3	Mortgage loans		
12.4	Real estate		
12.5	Other invested assets		
12.6	Net gains or (losses) on cash, cash equivalents and short-term investments		
12.7	Miscellaneous proceeds		
12.8	Total investment proceeds (Lines 12.1 to 12.7)	75,000	363,325
13.	Cost of investments acquired (long-term only):		
13.1	Bonds	211,140	424,058
13.2	Stocks		
13.3	Mortgage loans		
13.4	Real estate		
13.5	Other invested assets		
13.6	Miscellaneous applications		
13.7	Total investments acquired (Lines 13.1 to 13.6)	211,140	424,058
14.	Net increase (or decrease) in policy loans and premium notes		
15.	Net cash from investments (Line 12.8 minus Lines 13.7 and 14)	(136,140)	(80,733)
Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):		
16.1	Surplus notes, capital notes	0	
16.2	Capital and paid in surplus, less treasury stock		
16.3	Borrowed funds		
16.4	Net deposits on deposit-type contracts and other insurance liabilities		
16.5	Dividends to stockholders		
16.6	Other cash provided (applied)		
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.6 minus Line 16.5 plus Line 16.6)	0	
RECONCILIATION OF CASH AND SHORT-TERM INVESTMENTS			
18.	Net change in cash and short-term investments (Lines 11 plus 15 plus 17)	(1,742,260)	1,941,798
19.	Cash and short-term investments:		
19.1	Beginning of year	5,283,074	3,341,278
19.2	End of period (Line 18 plus Line 19.1)	3,540,814	5,283,074

Supplemental Disclosures of Cash Flow Information for Non-Cash Transactions:

Description	Amount	Amount
	1	2
29,0001		

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Total	Comprehensive Hospital & Medical Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	The Mill Healthcare	The XOC Healthcare	Stop Loss	Disability Income	Long-Term Care	Other
Total Members at Period:													
1. Plan Year	27,255	189	11,013				1,051		62,952				
2. First Quarter	76,757	147	10,558				2,853		83,185				
3. Second Quarter													
4. Third Quarter													
5. Current Year													
6. Current Year Member Months	229,455	643	31,485				8,751		183,776				
Total Member Ambulatory Encounters for Period:													
7. Physician	154,790	298	21,240				5,903		127,348				
8. Non-Physician													
9. Total	154,790	298	21,240				5,903		127,348				
10. Hospital Patient Days Incurred	9,168	10	683				490		8,285				
11. Number of Inpatient Admissions	1,539	2	151				46		1,740				
12. Health Premiums Written	44,716,889	137,081	6,572,543				1,922,485		35,084,851				
13. Life Premiums Direct													
14. Property/Casualty Premiums Written													
15. Health Premiums Earned	44,716,889	137,081	6,572,543				1,922,485		35,084,851				
16. Property/Casualty Premiums Earned													
17. Amount Paid for Provision of Health Care Services	40,271,437	134,117	6,976,339				1,838,665		31,822,916				
18. Amount Incurred for Provision of Health Care Services	38,213,614	269,119	5,046,810				1,771,850		31,408,975				

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C

**QUARTERLY STATEMENT
OF THE
OMNICARE HEALTH PLAN**

**of
Detroit
in the state of
Michigan**

**TO THE
Insurance Department
OF THE STATE OF
Michigan**

**FOR THE QUARTER ENDED
September 30, 2004**

RECEIVED

DEC 14 2004

MSA/MCPD

2004



HEALTH QUARTERLY STATEMENT
AS OF September 30, 2004
OF THE CONDITION AND AFFAIRS OF THE
OMNICARE HEALTH PLAN

NAIC Group Code 0000 (Current Period) 0000 (Prior Period) NAIC Company Code 95582 Employer's ID Number 38-2031377

Organized under the Laws of Michigan State of Domicile or Port of Entry Michigan

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[] Property/Casualty[] Hospital, Medical & Dental Service or Indemnity[]
 Dental Service Corporation[] Vision Service Corporation[] Health Maintenance Organization[X]
 Other[] Is HMO Federally Qualified? Yes[X] No[]

Date Incorporated or Organized 09/23/1972 Date Commenced Business 12/23/1973

Statutory Home Office 1155 Brewery Park, Suite 250 Detroit, MI 48207
 (Street and Number) (City, or Town, State and Zip Code)

Main Administrative Office 1155 Brewery Park, Suite 250
 (Street and Number) Detroit, MI 48207 (313)393-0200
 (City or Town, State and Zip Code) (Area Code) (Telephone Number)

Mail Address 1155 Brewery Park, Suite 250 Detroit, MI 48207
 (Street and Number or P.O. Box) (City, or Town, State and Zip Code)

Primary Location of Books and Records 1155 Brewery Park, Suite 250
 (Street and Number) Detroit, MI 48207 (313)393-0200
 (City, or Town, State and Zip Code) (Area Code) (Telephone Number)

Internet Website Address www.ochp.com (313)393-6715
 (City, or Town, State and Zip Code) (Area Code) (Telephone Number)

Statutory Statement Contact Timothy P Priebe, Controller (313)393-6715
 (Name) (Area Code)(Telephone Number)(Extension)

lpriebe@ochp.com (313)393-4743
 (E-Mail Address) (Fax Number)

Policyowner Relations Contact _____
 (Street and Number)

 (City, or Town, State and Zip Code) (Area Code) (Telephone Number)(Extension)

OFFICERS

James Gerber, Special Deputy Liquidator

OTHERS

DIRECTORS OR TRUSTEES

Herman B. Gray M.D.
 Tej Mattoo M.D.

George Shade M.D.

State of Michigan
 County of Wayne ss

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manuals except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

James Gerber
 (Signature)
 James Gerber
 (Printed Name)
 Special Deputy Liquidator
 (Title)

 (Signature)

 (Printed Name)

 (Title)

 (Signature)

 (Printed Name)

 (Title)

Subscribed and sworn to before me this 4th day of November 2004

[Signature]
 (Notary Public Signature)

- a. Is this an original filing? _____
 b. If no, 1. State the amendment number _____
 2. Date filed _____
 3. Number of pages attached _____

Yes[X] No[]

LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$..... reinsurance ceded)	18,686,163	242,928	18,929,092	20,735,083
2. Accrued medical incentive pool and bonus amounts	1,003,825		1,003,825	869,646
3. Unpaid claims adjustment expenses	119,820		119,820	164,628
4. Aggregate health policy reserves				
5. Aggregate life policy reserves				
6. Property/casualty unearned premium reserve				
7. Aggregate health claim reserves				
8. Premiums received in advance				
9. General expenses due or accrued	2,562,875		2,562,875	2,853,210
10.1 Current federal and foreign income tax payable and interest thereon (including \$..... on realized gains (losses))				
10.2 Net deferred tax liability				
11. Ceded reinsurance premiums payable				
12. Amounts withheld or retained for the account of others				
13. Remittances and items not allocated				
14. Borrowed money (including \$..... current) and interest thereon \$..... (including \$..... current)				
15. Amounts due to parent, subsidiaries and affiliates				
16. Payable for securities				
17. Funds held under reinsurance treaties with (\$..... authorized reinsurers and \$..... unauthorized reinsurers)				
18. Reinsurance in unauthorized companies				
19. Net adjustments in assets and liabilities due to foreign exchange rates				
20. Liability for amounts held under uninsured accident and health plans				
21. Aggregate write-ins for other liabilities (including \$..... current)				
22. Total liabilities (Lines 1 to 21)	22,372,683	242,928	22,615,611	24,622,567
23. Common capital stock	X X X	X X X		
24. Preferred capital stock	X X X	X X X		
25. Gross paid in and contributed surplus	X X X	X X X		
26. Surplus notes	X X X	X X X	13,977,132	13,977,132
27. Aggregate write-ins for other than special surplus funds	X X X	X X X		
28. Unassigned funds (surplus)	X X X	X X X	(30,373,776)	(26,489,667)
29. Less treasury stock, at cost:				
29.1 ... shares common (value included in Line 23 \$.....)	X X X	X X X		
29.2 ... shares preferred (value included in Line 24 \$.....)	X X X	X X X		
30. Total capital and surplus (Lines 23 to 28 minus Line 29)	X X X	X X X	(16,396,644)	(12,512,535)
31. Total liabilities, capital and surplus (Lines 22 and 30)	X X X	X X X	6,218,967	12,110,032
DETAILS OF WRITE-INS				
2101				
2102				
2103				
2198. Summary of remaining write-ins for Line 21 from overflow page				
2199. TOTALS (Lines 2101 through 2103 plus 2198) (Line 21 above)				
2701	X X X	X X X		
2702	X X X	X X X		
2703	X X X	X X X		
2798. Summary of remaining write-ins for Line 27 from overflow page	X X X	X X X		
2799. TOTALS (Lines 2701 through 2703 plus 2798) (Line 27 above)	X X X	X X X		

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D



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
 QUALITY ASSURANCE ASSESSMENT
 HEALTH MAINTENANCE ORGANIZATIONS
INVOICE - DELINQUENT NOTICE

Issued under authority of MCL 500.224b.

Failure to submit payment by the date due will result in a penalty as prescribed by law.

BOBBY JONES, CEO
 OMNICARE HEALTH PLAN
 1333 GRATIOT
 SUITE 400
 DETROIT MI 48207

INVOICE NUMBER: 140826
 Invoice Date: September 1, 2004
 Notice Date: January 9, 2005

Health Plan:
 OMNICARE

If payment is not received by the due date, a 5% penalty will be assessed for each month that the assessment is not paid up to a maximum of 50% of the assessment. Please direct questions to Cheryl Bupp at (517) 241-7933.

Reference #:
 7000503

Invoice Item	Quantity	Unit Cost	Total Cost
QUALITY ASSURANCE ASSESSMENT From: 01-JUL-2004 To: 30-SEP-2004 \$2,562,875.00 PREMIUMS * 1	1	\$2,562,875.00	\$2,562,875.00

Principal:	\$2,562,875.00
Sales Tax:	\$0.00
Late Payment Penalty:	\$384,431.25
Total Invoice:	\$2,947,306.25
Payments:	\$0.00
Amount Due:	\$2,947,306.25

Payment due upon receipt

MAKE CHECK OR MONEY ORDER PAYABLE TO: STATE OF MICHIGAN
 TO ENSURE PROPER CREDIT, SEND THIS PORTION WITH PAYMENT TO:
 MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
 CASHIER'S OFFICE
 P.O. BOX 30437

INVOICE NO:
140826
 QAA HMO

LANSING MI 48909
 (Please note or make any mailing corrections below)

Reference #: 7000503

BOBBY JONES, CEO
 OMNICARE HEALTH PLAN
 1333 GRATIOT
 SUITE 400
 DETROIT MI 48207

For Cashier's Use Only: