MICHIGAN REGULATORY REQUIREMENTS MANUAL

Meridian Health Plan of Michigan ("Plan") contracts with various network providers, hospitals, ancillary providers, specialists and other practitioners ("You" or "Provider"). To the extent that you are a Provider contracted with Plan, this Regulatory Requirements Manual (the "Manual") incorporates various sections required by law, regulation or a regulatory body into your agreement with Plan. The applicable sections of this Manual will control in the event of a conflict with your agreement. Meridian will update this Manual as there are changes to state and federal laws, regulations, guidance or in the case of Medicare or Medicaid (or other related program) requirements, as Meridian's agreements with Payors are revised. Nothing in this Manual or the Agreement releases you from any independent obligation to comply with applicable statutory or regulatory authority.

Without limiting the generality of the foregoing, and notwithstanding anything in the agreement to the contrary, Provider has agreed to comply with the applicable requirements based on the selected networks Provider has agreed to participate in with Plan:

Michigan Statutory/Regulatory Requirements

1. Provider is prohibited from seeking payment from Enrollees for services provided, except for applicable copayments and deductibles, which may be collected directly from Enrollees. [MI ADC R. 325.6345(2)]
2. Provider must meet applicable licensure or certification requirements [MI ADC R. 325.6345(3)(a)]
3. Provider must allow appropriate access to records or reports concerning services to Enrollees [MI ADC R. 325. 6345(3)(b)]
4. Provider must cooperate with Plan's quality assurance activities. [MI ADC R. 325. 6345(3)(c)]

Medicare Regulatory Requirements

Where Provider provides services to Medicare Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Provider shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual. Plan's payment of such interest shall be Provider's sole remedy for Plan's failure to pay a Clean Claim within the applicable time period and shall be inclusive of any applicable penalties.

7. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

(i) The delegated activities and reporting responsibilities are specified in the Agreement, if any.

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.
[42 C.F.R. §§ 422.504(i)(4) and (5)]

Medicaid Requirements

Definitions:

Medicaid Enrollee means an Enrollee in any of Plan's Medicaid products.

MDHHS means the Michigan Department of Health and Human Services.

MIChild means the program using State funds as well as funds authorized under Title XXI of the Federal Social Security Act to furnish health care coverage to a targeted population. This population consists of individuals under age 19 who are not eligible for Medicaid, whose family income is above 150% and at or below 212% of the federal poverty level, and who do not have comprehensive health coverage. Final determination of eligibility is made by the Department of Community Health and may be subject to change.

Where Provider provides services to Medicaid Enrollees of Plan, including Medicaid Enrollees under the MICHILD program, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

1. Provider shall not seek payment from any Enrollee for any Covered Services provided to the Enrollee within the terms of the Agreement. Provider shall look solely to Plan for compensation for Covered Services rendered. No cost sharing or deductibles can be collected from Enrollees. Co-Payments are only permitted with MDHHS approval. [1.022(U)(1)(a)]

2. Provider shall cooperate with Plan's quality improvement and utilization review activities. [1.022(U)(1)(b)]

3. In the event that Plan determines that the health or safety of an Enrollee is in jeopardy, Provider shall cooperate with Plan to immediately transfer the Enrollee to another Provider. [1.022(U)(1)(c)]

4. Provider is not prohibited from discussing treatment options with Enrollees that may not reflect Plan's position or may not be covered by Plan. [1.022(U)(1)(d)]

5. Provider is not prohibited from advocating on behalf of an Enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services. Provider, when acting within the lawful scope of practice, is not prohibited, or otherwise restricted , from advising or advocating on behalf of an Enrollee who is his or her patient: (i) For the Enrollee' health status, medical care, or treatment options, including any alternative treatment that may be self-administered (ii) For any information the enrollee needs in order to decide among all relevant treatment options, (iii) For the risks, benefits, and consequences of treatment or non-treatment, and (iv) For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. [1.022(U)(1)(e)]

6. Provider shall meet all Medicaid accessibility standards as set forth in Plan's Agreement with the State of Michigan. [1.022(U)(1)(f)]

7. For Providers that are PP/PPGs, upon termination of the Agreement the Provider will continue to provide Covered Services to Enrollees that Provider is actively treating at the time of termination in accordance with dictates of medical prudence until PP/PPG completes such treatment or for up to ninety (90) calendar days, whichever is less, until Plan makes arrangements to have another Participating Provider provide such services. Care must be continued through the postpartum period for Enrollees in their second or third trimester of pregnancy, if applicable. The provisions of this Agreement, including those pertaining to Provider's compensation for Primary Care Services or Specialty Care Services, shall continue to apply after termination of this Agreement to all Covered Services provided by Provider prior to termination of this Agreement and to all post-termination Covered Services provided by Provider pursuant to this Section.

For all other providers, upon termination of the Agreement, the rights of each party hereunder shall terminate, provided however, that Provider shall be required to treat Enrollees receiving authorized treatment at the time of termination of this Agreement until Enrollee is discharged. Plan shall be required to pay Provider pursuant to payment terms of this Agreement for all services performed in connection with such treatment. Subject to treatment concerns of the Enrollee including continuity of care involving attending specialists and availability of alternative providers, Plan shall use its best efforts to arrange for the reassignment and transfer of Enrollees as soon as possible following the termination of this Agreement. Provider agrees, in the event of termination of this Agreement, to cooperate with Plan in the orderly transfer of Enrollees being treated or evaluated. [1.022(U)(1)(g)]

8. If Plan utilizes co-payments for Covered Services, Provider shall not deny services to an individual who is eligible for the services due to the Enrollee's inability to pay the copayment. [1.022(U)(1)(h)]

9. If Provider is a Primary Care Provider (PCP), such Provider shall provide or arrange for coverage of services twenty four (24) hours per day, seven (7) days per week. [1.022(R)(2)(l) and 1.022(S)(2)]

10. If Provider is a PCP, such Provider shall be available to see Enrollees a minimum of twenty (20) hours per practice location per week. [1.022(R)(2)(m)]

11. Provider shall hold Enrollee's harmless for any of the following provisions consistent with 42 CFR 438.106 and 42 CFR438.116: (a) Plan's debts, in case of insolvency, (b) Covered Services under Plan's agreement with MDHHS provided an Enrollee for which MDHHS did not pay Plan, (c) Covered Services provided to an Enrollee for which MDHHS or Plan does not pay Provider due to contractual, referral or other arrangement, and (d) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if Plan provided the services directly. [1.022(Y)(6)]

12. If Provider is a Hospital, such provider must comply with all medical record requirements contained within 42 CFR 456.101 – 456.145. [1.022(U)(i)]

13. Provider will provide to Plan and make available any medical records, required data, reports of services, and reports on complaints on grievances, quality, or utilization issues for Enrollees.

14. The Parties agree that Provider, in performing Provider's duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve Provider of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the MDHHS or DIFS in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to Provider, and only to the sums provided for herein, and that Provider shall be solely responsible for reimbursement and/or payment of any employee or agent of Provider for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.

15. Anything herein to the contrary notwithstanding, no term or provision of this Agreement shall operate to terminate the legal responsibility of Plan to the MDHHS, in concurrence with the DIFS, with respect to Enrollees eligible for benefits under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act. Provider agrees that no subcontract can terminate the legal responsibility of Provider to MDHHS with respect to Enrollees eligible for benefits under Title XIX and Title XXI of the Social Security Act.

16. Provider will assist Plan in meeting its obligations under Plan's agreement with the MDHHS, in concurrence with DIFS with respect to Enrollees eligible for benefits under Title XIX of the Social Security Act (Medicaid), and hereby agrees to the terms and conditions of such agreement as they pertain or apply to subcontractors.

17. Provider shall provide care to Enrollees in a culturally sensitive manner.

MI Health Link Regulatory Requirements

CMS and MMDHHS each require that specific terms and conditions be incorporated into the Agreement between Plan and First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS or MMDHHS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Where Provider provides services to MI Health Link (also may be referred to in the Agreement as MMAI or MMP) Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an Plan (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an Plan or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("Plan"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the Plan by common ownership or control and (1) performs some of the Plan's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the Plan at a cost of more than $2,500 during a contract period.

Required Provisions:

First Tier, Downstream or Related Entity agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, through 10 years from the final date of the final contract period of the contract entered into between CMS and the Plan or from the date of completion of any audit, whichever is later.

2. First Tier, Downstream or Related Entity will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the Plan.

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. First Tier, Downstream or Related Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source.

5. Any services or other activity performed in accordance with a contract or written agreement by First Tier, Downstream or Related Entity are consistent and comply with the Plan's contractual obligations.

6. Contracts or other written agreements between the Plan and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The Plan is obligated to pay contracted providers under the terms of the contract between the Plan and the provider. In accordance with 42 C.F.R. § 422.520(b), Provider shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual. Plan's payment of such interest shall be Provider's sole remedy for Plan's failure to pay a Clean Claim within the applicable time period and shall be inclusive of any applicable penalties.

7. First Tier, Downstream or Related Entity and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions.

8. If any of the Plan's activities or responsibilities under its contract with CMS are delegated to any First Tier, Downstream or Related entity:
    a. The delegated activities and reporting responsibilities are specified in the Agreement, if any.
    b. CMS and the Plan reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the Plan determine that such parties have not performed satisfactorily.
    c. The Plan will monitor the performance of the parties on an ongoing basis.
    d. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Plan or the credentialing process will be reviewed and approved by the Plan and the Plan must audit the credentialing process on an ongoing basis.
    e. If the Plan delegates the selection of providers, contractors, or subcontractor, the Plan retains the right to approve, suspend, or terminate any such arrangement.

9. First Tier, Downstream, or Related Entity must notify Plan within fourteen (14) calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") involving the Plan, First Tier, Downstream, or Related Entity, or an officer or director of Plan or First Tier, Downstream, or Related Entity, that arises during the term of the Agreement, including:
    a. A criminal Proceeding;
    b. A parole or probation Proceeding;
    c. A Proceeding under the Sarbanes-Oxley Act;
    d. A civil Proceeding involving:
        i. A Claim that might reasonably be expected to adversely affect Plan's viability or financial stability; or
        ii. A governmental or public entity's claim or written allegation of Fraud; or

iii. A Proceeding involving any license that Plan is required to possess in order to perform under this Contract.

10. Nothing in this Agreement shall require as a condition of joining the MI Health Link Network that Provider must also participate in Plan's other lines of business (e.g., commercial managed care network).

11. Nothing in this Agreement shall dictate Provider's terms of panel participation with other ICOs.

12. Nothing in this Agreement shall be read to directly or indirectly prohibit, through incentives or other means, limits, or discourages Provider from participating as network or non-network Provider in a provider network besides from those included in this Agreement.

13. Plan shall be able to perform an annual review to assure that the health care professionals under contract with First Tier, Downstream, and Related Entities are qualified to perform the services covered under the Agreement. Plan shall report to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a provider's license.

14. Nothing in the Agreement shall be interpreted as reducing Plan's responsibility for meeting all of the terms and requirements of the Three-Way Contract regardless of whether Plan subcontracts for performance of any Three-Way Contract responsibility. Each First Tier, Downstream or Related Entity shall meet all terms and requirements of the Three-Way Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve Plan of its legal responsibilities under the Three-Way Contract.

15. First Tier, Downstream or Related Entities shall meet the same federal and State financial and program reporting requirements as Plan. Plan shall evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.240.

16. First Tier, Downstream or Related Entities shall afford Enrollees the opportunity and assistance with filing a Grievance, Appeal, or State Fair Hearing, and shall follow procedures and timeframes for doing so, as well as the rules for representation at hearing, as indicated in Plan Policies. First Tier, Downstream or Related Entities shall permit an Enrollee to request continuation of benefits if the Enrollee files an Appeal or a request for a State Fair Hearing within specified timeframes. Plan provides the toll-free numbers to file oral grievances and appeals to First Tier, Downstream or Related Entities in its Plan Policies.

17. Plan shall subject the First Tier, Downstream or Related Entities' performance to formal review according to a periodic schedule established by the State of Michigan, consistent with industry standards or State laws and regulations.

18. If First Tier, Downstream or Related Entity is delegated responsibilities for Utilization Management, First Tier, Downstream or Related Entity shall meet all requirements for Utilization Management as indicated in Plan Policies.

19. Providers that are Primary Care Providers and specialty providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

20. An Enrollee, or an authorized representative, may file an internal Enrollee Grievance at any time with Plan or its providers by calling or writing to Plan or Provider. If the internal Enrollee Grievance is filed with Provider, Provider shall forward it to Plan. If remedial action is requested regarding a Medicare issue, the Enrollee must file the Grievance with the Plan or Provider no later than ninety (90) calendar days after the event or incident triggering the Grievance.

21. First Tier, Downstream or Related Entity shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in the Three-Way Contract, Appendix D thereof and Plan Policies.

22. First Tier, Downstream or Related Entity shall be fully compliant with all State and federal laws, regulations, and policies governing the Appeal and State Fair Hearing process, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. First Tier, Downstream or Related Entity agrees to assist Plan in cooperation with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929 (Patients Right to Independent Review Act or PRIRA) for the Appeal of a Medicaid service.

23. Nothing in this Agreement shall be read to require that compensation to First Tier, Downstream, or Related Entity (if such First Tier, Downstream, or Related Entity conducts Utilization Management activities) is structured so as to provide incentives for First Tier, Downstream, or Related Entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

24. First Tier, Downstream or Related Entity shall provide:

    a. All information CMS and MMDHHS require under the Three-Way Contract related to the performance of Plan's responsibilities, including non-medical information for the purposes of research and evaluation;

    b. Any information CMS and MMDHHS require to comply with all applicable federal or State laws and regulations; and

    c. Any information CMS or MMDHHS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and Enrollment/disenrollment rates.

25. First Tier, Downstream or Related Entity shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. First Tier, Downstream or Related Entity shall assist Plan to submit all information required to be disclosed to CMS and MMDHHS in the manner and format specified by CMS and MMDHHS which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

26. First Tier, Downstream or Related Entity shall require each physician providing Covered Services to Enrollees participating in MI Health Link to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b) such that Plan can provide such unique identifier to CMS and MMDHHS for each of its Primary Care Practitioners in the format and time-frame established by CMS and MMDHHS in consultation with the Plan.

27. In accordance with 42 USC §1396 u-2(b)(3), nothing in this Agreement shall prohibit or otherwise restrict a provider or clinical First Tier, Downstream, or Related Entity of Plan from advising a Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Three-Way Contract, if the provider or clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

28. All information and documentation that: a) has been marked "confidential" or with words of similar meaning, at the time of disclosure by such party; b) if disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning; and, c) should reasonably be recognized as confidential information of the disclosing party, but not any information or documentation that was: i) subject to disclosure under the Michigan Freedom of Information Act (FOIA); ii) already in the possession of the receiving party without an obligation of confidentiality; iii) developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights; iv) obtained from a source other than the disclosing party without an obligation of confidentiality; or, v) publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party) is "Confidential Information". Confidential Information shall held in strict confidence and First Tier, Downstream, or Related Entity shall not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or First Tier, Downstream or Related Entities of a party who have a need to know in connection with this Agreement and the Three-Way Contract or to use such Confidential Information for any purposes whatsoever other than the performance of Provider's Agreement. The parties agree to advise and require their respective employees, agents, and First Tier, Downstream, and Related Entities of their obligations to keep all Confidential Information confidential. At the State of Michigan's request, any employee of Plan or any First Tier, Downstream, or Related Entity may be required to execute a separate agreement to be bound by the provisions of this Section.

29. Neither Plan nor First Tier, Downstream or Related Entity may, for the duration of the Three-Way Contract, have any interest that will conflict, as determined by CMS and MMDHHS with the performance of services under the Three-Way Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and MMDHHS require that neither Plan nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing ICO Enrollment functions for MMDHHS.

30. The Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General or his or her designee, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of First Tier, Downstream or Related Entity that pertains to the ability of Plan to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

31. To the extent that First Tier, Downstream or Related Entity performs functions on Plan's behalf related to the operation of the Part D benefit under MI Health Link shall be performed in compliance with 42 C.F.R. §423.505(i).

32. All activities delegated by Plan to First Tier, Downstream or Related Entity related to the operation of the Medicare-Medicaid Plan shall be performed in compliance with 42 C.F.R. §§422.504, 423.505, 438.6(l), and 438.230(b)(1).

33. First Tier, Downstream or Related entities agrees that HHS, the Comptroller General, MMDHHS or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation, and any other pertinent information of the First Tier, Downstream or Related Entity for ten (10) years from the final date of Three-Way Contract or from the date of completion of any audit, whichever is later.

34. Provider shall not hold an Enrollee liable for payment of any fees that are the obligation of Plan.

35. Any services or other activity performed by a First Tier, Downstream or Related Entity must be performed in accordance with Plan's contractual obligations to CMS and MMDHHS.

36. All delegated activities and reporting requirements are specified in the Agreement. Any delegation may be revoked among all other legal remedies in an instance where CMS, MMDHHS or Plan determine that such party have not performed satisfactorily.

37. Provider agrees that performance of the parties is monitored by Plan on an ongoing basis and Plan may impose corrective action as necessary.

38. First Tier, Downstream or Related Entity agrees to safeguard Enrollee Privacy and confidentiality of Enrollee health records.

39. First Tier, Downstream or Related Entity must comply with all Federal and State laws, regulations and CMS instructions.

40. In the event that the Agreement allows or requires First Tier, Downstream or Related Entity to perform credentialing of medical providers, either of the following shall apply:

    a. The credentials of medical professionals affiliated with the party or parties will be either reviewed by Plan; or

    b. The credentialing process will be reviewed and approved by Plan and Plan must audit the credentialing process on an ongoing basis.

41. To the extent that the Agreement may delegate to First Tier, Downstream or Related Entity the selection of providers , Plan retains the right to approve, suspend, or terminate any such arrangement.

42. Neither Plan nor Provider has the right to terminate the portion of the Agreement to engage in the MI Health Link Network without cause and Provider shall provide at least 60 calendar day notice to Plan and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by Plan or Enrollee.

43. In the event that Provider is terminated for cause, Plan shall provide a written statement to Provider of the reason or reasons for termination with cause.

44. If First Tier, Downstream or Related Entity is a medical provider or First Tier, Downstream or Related Entity contracts or arranges for the provision of services from providers the following provisions shall be reflected in the contract(s) or arrangement(s) and if not so reflected, such provision shall apply as expressed herein:

    a. Plan is obligated to pay contracted medical providers under the terms of the contract between Plan and the medical provider. The agreement shall contain a prompt payment provision, the terms of which are developed and agreed to by both Plan and the relevant medical provider;

    b. Services shall be provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

    c. Medical providers shall abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and Enrollment information;

    d. Medical providers shall ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;

    e. Medical providers shall maintain the Enrollee Medical Record and information in an accurate and timely manner;

    f. Medical providers shall ensure timely access by Enrollees to the records and information that pertain to them; and

    g. No provider shall hold Enrollees liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees;

    h. Medical providers' EMTALA obligations shall be fulfilled as described by law and/or in the Agreement and nothing in the Agreement shall be interpreted to create any conflict with any hospital actions required to comply with EMTALA;

    i. Providers, including, but not limited to PCPs, shall not close or otherwise limit their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees;

    j. Plan may not refuse to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

        i. Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of Plan's health benefit plans as they relate to the needs of such provider's patients; or

        ii. Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by Plan for services provided to the patient.

    k. No provider shall be required to indemnify Plan for any expenses or liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any Claim or action brought against Plan based on Plan's management decisions, utilization review provisions or other policies, guidelines or actions directly related to the MI Health Link program;

l. Providers shall comply with Plan's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

m. Plan shall notify providers in writing of modifications in payments, modifications in Covered Services or modifications in Plan's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between Plan and the provider or unless such change is mandated by CMS or MMDHHS without 30 calendar days prior notice;

n. Providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable;

o. No payment shall be made by Plan to a provider for a Provider Preventable Condition;

p. As a condition of payment, the provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by Plan. The provider shall comply with such reporting requirements to the extent the provider directly furnishes services; and

q. Primary Care Providers and specialty providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

45. No agreement with a medical provider or First Tier, Downstream or Related Entity that contracts with, employs or arranges for the provision of services from medical providers shall include any incentive plan(s) that includes a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

    a. The provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

    b. Plan shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

46. Nothing in the Agreement shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation Payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph 46, below.

47. If First Tier, Downstream or Related Entity is a medical provider or First Tier, Downstream or Related Entity contracts or arranges for the provision of services from medical providers, Plan shall not impose a financial risk on medical providers for the costs of medical care, services or equipment provided or authorized by another physician or health care provider and such contract includes specific provisions with respect to the following:

    a. Stop-loss protection;

    b. Minimum patient population size for the physician or physician group; and

    c. Identification of the health care services for which the physician or physician group is at risk.

48. If First Tier, Downstream or Related Entity provides for laboratory testing sites providing services, such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

49. Nothing in the Agreement shall be construed to restrict or limit the rights of Plan to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

Commercial/Health Insurance Exchange Regulatory Requirements

Where Provider provides services to Plan, pursuant to its status as a Qualified Health Plan Issuer providing a Qualified Health Plan product(s) on an exchange or marketplace (the "Agreement") the following provisions shall be incorporated into the Agreement and shall control where conflicting:

HHS requires that specific terms and conditions be incorporated into the agreements between a Qualified Health Plan Issuer and all Delegated or Downstream Entities (as defined below) in order to comply with the Health Insurance Exchange laws, regulations, and US Department of Health and Human Services ("HHS") or the Centers for Medicare & Medicaid Services ("CMS") instructions; and

Except as provided herein, all other provisions of the Agreement between Meridian and Provider not inconsistent herein shall remain in full force and effect. This Addendum shall supersede and replace any inconsistent provisions to such Agreement to ensure compliance with required HHS provisions, and shall continue concurrently with the term of such Agreement.

Definitions:

Capitalized terms used in this Addendum that are not otherwise defined herein shall have the meanings set forth in the Agreement.

Delegated Entity means any party, including an agent or broker, that enters into an agreement with Meridian to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents. To the extent that Provider provides services to Meridian or Meridian's QHP or members thereof, Provider is a Delegated Entity.

Downstream Entity means any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Meridian. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Exchange or Health Insurance Marketplace means a governmental agency or non-profit entity that meets the applicable standards of 45 C.F.R. §155 subpart D and makes QHPs available to individuals and employers. This term includes both state and Federally-facilitated Exchanges.

Qualified Health Plan or ("QHP") means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Health Plan Issuer (*"QHP issuer")* means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange, such as Meridian.

QHP Issuer Agreement means the agreement between CMS and Meridian for Meridian to offer QHPs to Michigan residents through Federally-facilitated Health Insurance Marketplaces.

Required Provisions:

Where Provider provides services on Meridian's behalf related to Meridian's status as a QHP Issuer or to Meridian members enrolled in a Meridian QHP, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

1. Delegated Entity will comply with the standards of subpart C of part 156 as applicable to the services performed under the Agreement.

2. If any of Meridian's activities or responsibilities with regard to Meridian's QHP product are delegated to Delegated Entity those activities are listed in the Agreement and:

3. HHS and Meridian reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where HHS or Meridian determines that such parties have not performed satisfactorily. Delegated Entity shall reasonably cooperate with any transition plan subsequent to a revocation under this section. In no event shall any additional financial obligation(s) accrue against Meridian with respect to such revoked activity(ies) after the date of any revocation under this section.

4. Meridian will monitor the performance of the parties on an ongoing basis as provided for in the Agreement.

5. If Meridian delegates the selection of providers, contractors, or subcontractors, Meridian retains the right to approve, suspend, or terminate any such arrangement at its sole discretion.

6. Delegated Entity and any Downstream Entity must comply with all applicable laws and regulations relating to the standards of: 45 C.F.R. part 156 subpart C; all exchange processes, procedures, and standards in accordance with subparts H and K of part 155, and any applicable state statutes and regulations regarding the exchange and, in the small group market; 45 C.F.R. §155.705; 45 C.F.R. §155.220 with respect to assisting with enrollment in Meridian; and 45 C.F.R. §§156.705 and 156.715 for maintenance of records and compliance reviews for Meridian to the extent that it operates in a Federally-facilitated Exchange or FF-SHOP.

7. If Delegated Entity has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or Downstream Entities, directly or through another person or entity, to perform any services on behalf of a QHP, Delegated Entity shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Addendum as may be interpreted, supplemented or amended in accordance with the terms and conditions of this Addendum. Delegated Entity shall provide proof of such to Meridian upon request.

8. Delegated Entity and any Downstream Entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to Delegated Entity or any Downstream Entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Meridian's obligations in accordance with Federal standards under paragraph Section 3 herein until 10 years from the termination or expiration of the Agreement.