Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BLUE CROSS BLUE SHIELD OF MICHIGAN
MEDICARE ADVANTAGE
PPO PROVIDER AGREEMENT

This Medicare Advantage ("MA") PPO Provider Agreement ("Agreement") is entered into by Blue Cross Blue Shield of Michigan, a Michigan nonprofit healthcare corporation ("BCBSM") and the undersigned Provider who is fully licensed or legally authorized to practice in the state of Michigan ("Provider").

WHEREAS, BCBSM has, based on goals of quality, access and cost, established a MA PPO network and wishes to maintain a panel of Providers eligible to provide health care services to Members enrolled in a Blue Cross MA PPO plan through Providers affiliated with the MA PPO network and;

WHEREAS, Provider accepts these goals and wishes to be included in a limited panel of preferred providers affiliated with the MA PPO network and;

WHEREAS, Provider is able to provide health care services to Members enrolled in programs that utilize the MA PPO network and;

WHEREAS, BCBSM retains the right, at its sole discretion, to determine Members eligible for programs that utilize the coverage under the MA PPO network or for other program(s) and to reimburse or sanction Providers under contract provisions pertaining to the MA PPO network and other BCBSM program(s) and;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained in this Agreement, BCBSM and Provider agree as follows:

1. EFFECTIVE DATE

This Agreement shall become effective on the Effective Date as referenced on the Signature Document hereof. The Agreement shall remain binding until terminated pursuant to the termination provisions of this Agreement.

2. DEFINITIONS

The terms included herein shall have the meaning required by law to be applicable to BCBSM and Provider under the terms of BCBSM's contract with Centers for Medicare and Medicaid Services ("CMS") and the regulations promulgated in Title 42 CFR Parts 422 and 423.

2.1 Agreement. This document, and any Attachments or addenda including the Provider's application for participation, BCBSM's MA PPO Provider Manual ("MA PPO Provider Manual"), which is incorporated by reference herein, and such other documents and modifications as may be made pursuant to this document.

2.2 BCBSM Members (Members). A Medicare beneficiary entitled to receive coverage for certain health care services under the terms of the MA PPO Benefit Contract and whose enrollment with BCBSM has been confirmed by CMS.

2.3 **Beneficiary.** An individual entitled to and duly enrolled in Medicare.

2.4 **BCBSM MA PPO Provider Manual (MA PPO Provider Manual).** Comprehensive guidelines, policies and procedures as established and published by BCBSM for Participating Providers.

2.5 **Clean Claim.** A claim that: (1) has no defect, impropriety, lack of any BCBSM required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment; and (2) otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

2.6 **Copayment.** An amount due from Member as his or her portion of total compensation due to Provider for rendering Covered Services. As used herein the term Copayment shall be inclusive of any fixed dollar copayments per service, percentage co-insurance amounts per service or deductible amounts payable by Member before BCBSM assumes financial liability for payment of a Covered Service.

2.7 **Covered Services.** Those health care services rendered to a Member for which BCBSM shall provide coverage and payment in accordance with the terms of the MA PPO Benefit Contract and this Agreement.

2.8 **Medical Necessity (Medically Necessary).** Those health care services that Providers, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;

c. Not primarily for the convenience of the Member, Provider, or other health care provider.

2.9 **MA PPO Benefit Contract.** An individual contract between a Member and BCBSM or between an employer group or other entity and BCBSM under which a Member is entitled to receive Covered Services as described in the applicable MA PPO Evidence of Coverage ("EOC") document and Summary of Benefits ("SB") document.

2.10 **MA PPO Program**. A program to provide and pay for Covered Services to Members under an MA PPO Benefit Contract and its contract with CMS, authorized under Title XVIII, of the Social Security Act, as amended (otherwise known as Medicare).

2.11 **Medicare Service Area.** The area(s) approved by CMS as being the area(s) to which BCBSM may market and enroll Beneficiaries in its MA PPO Program. The MA PPO Program may include more than one MA plan with each plan having its own service area.

2.12 **Participating Provider or (Provider).** (1) Any individual who is engaged in the delivery of

health care services for Members in BCBSM's MA PPO network 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 for Members in BCBSM's MA PPO network and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation.

2.13 **Risk Adjustment Data.** All data that is used in the application of a risk adjustment payment model.

2.14 **Member Termination of Covered Service.** The discharge of a Member from Covered Services, or discontinuation of Covered Services, when Member has been authorized by BCBSM, either directly or by delegation, to receive an ongoing course of treatment from the Provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether Member agrees that such services should end.

2.15 **Pre-Service Review.** The process of obtaining authorization for medical treatment prior to select procedures or services. Pre-Service Review includes, but is not limited to, prenotification, precertification, preauthorization, and prior approval.

3. PROVIDER OBLIGATIONS

3.1 **Provision of Covered Services.** Provider agrees to render Covered Services to Members eligible for coverage under Title XVIII of the Social Security Act, as amended, in accordance with the terms and conditions of the MA PPO Program and BCBSM MA PPO Program requirements. Such BCBSM MA PPO Program requirements include the provisions of BCBSM's applicable EOC, operational policies and procedures, utilization management program and quality management program requirements with which Provider shall comply in rendering Covered Services. BCBSM shall supply Provider with the MA PPO Program requirements not set forth in this Agreement through its MA PPO Provider Manual and any amendments thereto. Determination of Covered Services shall be governed by coverage guidelines established by BCBSM and the MA PPO Program, with BCBSM being solely responsible for final coverage determination, subject to the applicable appeal procedures.

3.2 **Pre-Service Review.** The following requirements apply for inpatient facility admissions:

a. In addition to the requirements in Section 3.17 below related to MA PPO programs offered by other Blue Cross Blue Shield (BCBS) Plans, Provider shall perform Pre-Service Review when required by a BCBS Plan or BCBSM and provide such other information as a BCBS Plan or BCBSM may reasonably request to help manage patient care.

b. Effective September 1, 2015, if Provider fails to perform Pre-Service Review as required in Section 3.2a, and does not obtain retroactive Pre-Service Review within sixty (60) days of the date of admission, BCBSM shall reduce the payment on a Clean Claim for a Covered Service by thirty (30) percent.

c. Provider shall not bill or collect from a Member for Covered Services where Provider fails to perform Pre-Service Review as required in Section 3.2.a, or where Provider fails to obtain retroactive Pre-Service Review within sixty (60) days.

3.3 **Hospital Privileges.** If Provider is a physician, Provider shall maintain staff privileges at a hospital designated by BCBSM as a "participating" hospital in the MA PPO network. BCBSM may waive this requirement if Provider's practice does not require the maintenance of hospital staff privileges.

3.4 **Compliance.** Provider agrees to comply with BCBSM's policies and procedures including BCBSM, payment, billing and reimbursement policies, the MA PPO Provider Manual, BCBSM's contractual obligations to CMS, and all applicable federal, state and local laws, rules and regulations, now or hereafter in effect including Medicare laws, regulations, reporting requirements and CMS instruction, including, Member appeal and dispute resolution procedures related to Covered Services provided to a Member. To the extent that Provider is involved in the administration or delivery of Medicare prescription drug benefits under Medicare Part D of the MA PPO Program, Provider shall comply with federal laws and regulations governing Medicare Part D coverage determinations, grievances and appeals, and formulary exceptions, and acknowledges that these requirements are separate and distinct from the appeals and grievances requirements under Medicare Part C of the MA PPO Program. Payments from BCBSM to Provider are made, in whole or in part, from Federal funds, and subject Provider to all laws applicable to the individuals or entities who receive Federal funds, including the False Claims Act (32 USC 3729, *et seq*.), the Anti-kickback Statute (Section 1128B(b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR Part 160, 162, and 164, and the Rehabilitation Act of 1973. Provider agrees to comply with all of such federal laws and regulations. Should Provider be out of compliance with any applicable law, regulations, policies or procedures, Provider will be afforded a 90 day period to cure any such noncompliance. Failure to cure any noncompliance may result in BCBSM's exercise of its immediate termination rights pursuant to Section 6.3. Notwithstanding anything to the contrary in this Section, CMS shall retain its right to terminate this Agreement at any time.

3.5 **Medical Management and Quality Improvement Program.** Provider shall cooperate and comply with BCBSM medical policies and quality improvement, performance improvement, medical management programs and credentialing or privileging specific to a particular procedure. Such cooperation and compliance shall include, but not be limited to, making all information regarding medical policy, medical management and quality improvement available to BCBSM and CMS upon request, and providing to BCBSM such data as may be necessary to implement its MA PPO Program's quality improvement program and credentialing and recredentialing requirements. Provider shall also participate in CMS and the U.S. Department of Health and Human Services ("HHS") quality improvement initiatives. To the extent applicable in connection with Provider's administration or delivery of prescription drug benefits under Part D of the MA PPO Program, Provider shall cooperate with BCBSM's quality assurance, drug utilization management and medication therapy management programs, and shall support e-prescribing.

3.6 **Non-Discrimination.** Provider shall not discriminate against any Member in the provision of Covered Services on the basis of Member's coverage under a MA PPO Program, age,

gender, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services or supplies, claim experience, medical history, evidence of insurability (including conditions arising out of domestic violence), genetic information, or other unlawful basis including, without limitation, the filing by such Member of any complaint, grievance or legal action against Provider or BCBSM.

3.7 **Noninterference with Advice to Members.** Nothing in the Agreement is intended to prohibit or restrict Provider from advising or advocating on behalf of a Member regarding: (1) Member's health status, medical care, or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to Member to provide an opportunity to decide among all relevant treatment options; (2) the risks, benefits and consequences of treatment or non-treatment; and (3) the opportunity for Member to refuse treatment and express preferences about future treatment decisions. Provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Provider must assure that individuals with disabilities are furnished with effective communications in making decisions regarding treatment options.

3.8 **Prohibition on Removal of Members.** Neither Provider nor Provider's employees shall request, demand, require or otherwise seek, directly or indirectly, the termination of any Member's coverage based upon Member's need for or utilization of medically required services, or in order to gain financially or otherwise from such termination. Provider may request that BCBSM terminate coverage of a Member for reasons of fraud, disruption of medical services, or failure to follow a physician's orders, or for any of the reasons specified by CMS for mandatory disenrollment. Provider agrees that BCBSM shall have sole and ultimate authority to request termination of a Member's coverage, and Provider understands any requested termination is subject to prior approval by CMS.

3.9 **Audit and Record Maintenance.** Provider will maintain timely and accurate medical, financial, and administrative records related to Covered Services rendered by Provider. Unless a longer time period is required by applicable statutes or regulations, Provider shall maintain such records and any related contracts for ten (10) years after the final date of this Agreement or completion of audit, whichever is later. Provider shall give any authorized local, state, or federal government agency, including without limitation BCBSM, HHS, U.S. General Accounting Office ("GAO"), the Comptroller General, CMS, and their authorized designees, the right to audit, evaluate, collect directly from, and inspect all physical premises, books, contracts, records, including medical records, and documentation of Provider involving transactions related to CMS' contract with BCSBM during the term of this Agreement and for a period of ten (10) years following termination or expiration of this Agreement for any reason, or until completion of an audit, whichever is later.

3.10 **CMS Risk Adjustment Data Validation Audit**. Provider will include supporting documentation in a Member's medical record for all diagnosis codes submitted by Provider to BCBSM for payment consistent with CMS Guidelines. In the event of a CMS Risk Adjustment Data Validation (RADV) audit, Provider will be required to submit medical records for the validation of risk adjustment data. Provider acknowledges its obligation to cooperate with BCBSM and/or CMS during such audits and to timely produce requested medical records in accordance with 42 CFR 422.310(e) and/or attestations to correct signature

deficiencies in the medical record.

3.11 Confidentiality. Provider agrees to establish procedures to do the following:

a. Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Provider must safeguard the privacy of any information that identifies a particular Member and have procedures that specify:

1. For what purposes the information will be used within the organization, and

2. To whom and for what purposes it will disclose the information outside the organization.

b. Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

c. Maintain the records and information in an accurate and timely manner.

d. Ensure timely access by enrollees to the records and information that pertain to them.

3.12 Monitoring and Corrective Action. Provider shall internally monitor and audit its responsibilities and activities with respect to such administration and delivery of health care services under this Agreement, including documenting any potential noncompliance or potential Fraud, Waste and Abuse (FWA) identified via audit, monitoring, or otherwise, by BCBSM, HHS, GAO, or CMS. Provider shall take corrective action to remedy any deficiencies found as appropriate. Upon request, Provider shall provide BCBSM with the results of any audits related to the provision of services to Members. Additionally, Provider shall allow BCBSM, HHS, GAO, and/or CMS to oversee its documentation and implementation of corrective actions related to potential noncompliance or potential FWA.

3.13 Reports, Administration, and Certification of Accuracy. Provider agrees to provide BCBSM with all data necessary to characterize the context and purposes of each encounter between Provider and a Member, to facilitate claims adjudication in accordance with CMS encounter reporting requirements, and to monitor Provider's performance under this Agreement as required by law. Provider certifies, based on best knowledge, information, and belief, the accuracy, completeness, and truthfulness of any data Provider shall submit to BCBSM that characterizes the context and purposes of each service provided to a Member by Provider or characterizes the functional limitations of Members. BCBSM shall have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of federal, state and local governmental agencies having jurisdiction over BCBSM. BCBSM shall perform all the necessary administrative, accounting, enrollment and other functions appropriate for the marketing and administration of its MA PPO Program.

3.14 Hold Harmless. Provider shall not hold a Member liable for any payment of fees that are the legal obligation of BCBSM or for Medicare Parts A and B cost-sharing that are the legal obligation of BCBSM or the State. Provider shall accept BCBSM's reimbursement,

pursuant to one or more Exhibits or Attachments attached to this Agreement, as payment in full for the rendering of Covered Services to Members. Provider hereby agrees that in no event, including, but not limited to, nonpayment by BCBSM, the insolvency of BCBSM, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on behalf of a Member other than BCBSM for Covered Services. This provision shall not prohibit collection of any applicable Copayments billed in accordance with the terms of the Member's MA PPO Benefit Contract. Provider shall not bill Member for services denied because Provider was not eligible for payment as determined by BCBSM based upon BCBSM credentialing or privileging policy for the particular service rendered. If BCBSM receives notice of any additional charge, Provider shall fully cooperate with BCBSM to investigate such allegations, and shall promptly refund any payment BCBSM deems improper to the party who made the payment. Provider further agrees that this provision shall survive the termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Members, and that this provision shall supersede any oral or written contrary agreement now existing or hereafter entered into between BCBSM or Provider and a Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under this Agreement.

3.15 **Credentialing and Re-credentialing.** Provider agrees to meet the credentialing and re-credentialing criteria, standards, and policies established by BCBSM, as may be amended from time to time. Provider shall comply with all credentialing and re-credentialing requirements set forth by CMS. These standards include maintenance of acceptable levels of any required liability insurance. BCBSM retains sole discretion to determine whether Provider shall be accepted as a Participating Provider pursuant to BCBSM's policies, rules, procedures, and contracting and credentialing standards. To the extent BCBSM delegates the selection of providers to Provider, BCBSM retains the right to approve, suspend, or terminate such arrangement.

3.16 **Provider's Notices to BCBSM.** Provider shall notify BCBSM, in writing, immediately of: (a) any termination, suspension, limitation, voluntary surrender, or restriction of Provider's professional license, accreditation, certification, permit, or other governmental authorization; (b) if applicable to Provider, any hospital disciplinary action or termination, suspension, limitation or restriction of professional staff appointments or clinical privileges; (c) failure to maintain any insurance as required herein; (d) Provider's or any of its affiliates' or principal employees' conviction of a felony or any other criminal charge involving the provision of health care or prescription drug services; (e) any disciplinary action taken by a state licensing board, the Drug Enforcement Agency ("DEA"), if applicable, or other governmental agency; (f) Provider's suspension or exclusion from participation in a Federal health care program as defined in 42 USC 1320a-7b(f) or a Federal procurement program; or (g) any other legal, governmental, or other action or event which may materially impair the Provider's ability to perform any duties and obligations under this Agreement.

3.17 **MA PPO Program Offered by another Blue Cross Blue Shield Plan.** Provider agrees to provide Covered Services to any Beneficiary covered by a MA PPO Program under which another Blue Cross Blue Shield Plan (BCBS Plan) is the payor of Covered Services provided to Beneficiaries, including complying with any Pre-Service Review requirements of the BCBS Plan, and to submit claims for payment to BCBSM for BCBSM's coordination

with the appropriate BCBS Plan in adjudicating the claim according to the person's MA PPO Benefit Contract. The provisions of this Agreement shall apply to charges for Covered Services under such programs. Provider shall accept reimbursement by BCBSM as payment in full for Covered Services provided to such persons except to the extent of Copayments.

3.18 **Publication of Participation.** Provider agrees to allow publication, distribution, and dissemination of the Provider's name and demographic information including, but not limited to, address, telephone number, and specialty.

3.19 **Member Notice of Termination of Certain Covered Services.** For Providers that are home health agencies ("HHAs"), skilled nursing facilities ("SNFs"), and comprehensive outpatient rehabilitation facilities ("CORFs"), prior to any Member termination of Covered Services, the Provider of the service must deliver valid written notice to Member of BCBSM's decision to terminate services. The Provider must use a standardized notice, required by the Secretary of HHS, in accordance with the following procedures:

(a) *Timing of notice.* The Provider must notify Member of BCBSM's decision to terminate Covered Services no later than two (2) days before the proposed end of the services. If Member's services are expected to be fewer than two (2) days in duration, the Provider should notify Member at the time of admission to the Provider. If, in a non-institutional setting, the span of time between services exceeds two (2) days, the notice should be given no later than the next to last time services are furnished.

(b) *Content of the notice.* The standardized termination notice must include the following information:

(i) The date that coverage of services ends.

(ii) The date that Member's financial liability for continued services begins.

(iii) A description of Member's right to a fast-track appeal, including information about how to contact an independent review entity (IRE), a Member's right (but not obligation) to submit evidence showing that services should continue, and the availability of other MA appeal procedures if Member fails to meet the deadline for a fast-track IRE appeal.

(iv) Member's right to receive detailed information.

(v) Any other information required by the Secretary of HHS.

(c) *When delivery of notice is valid.* Delivery of the termination notice is not valid unless:

(i) Member (or Member's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(ii) The notice is delivered in accordance with paragraph (a) of this section and contains all the elements described in paragraph (b) of this section.

(d) *Financial liability for failure to deliver valid notice.* Provider will indemnify BCBSM for any financial liability arising out of Provider's failure to deliver valid and timely notice.

3.20 **Compliance Plan.** Provider shall have a compliance plan that includes: (1) measures to detect, correct, and prevent fraud, waste, and abuse; and (2) written policies, procedures, and standards of conduct articulating Provider's commitment to comply with all applicable federal and state standards; (3) the designation of a compliance officer and compliance committee accountable to senior management and responsible for high level oversight of Provider's compliance plan; (4) effective training and education for Provider's compliance officer and Provider's employees, Governing Body members, and Downstream Entities, including training on FWA; (5) effective lines of communication between the compliance officer and BCBSM, and the compliance officer and Provider's employees, Governing Body members, and Downstream Entities; (6) enforcement of standards through well-publicized disciplinary actions; (7) procedures for effective and routine internal monitoring and auditing; and (8) procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives related to any evidence of fraud and misconduct.

Provider agrees to complete the Fraud, Waste, and Abuse (FWA) and general compliance training modules, available at the Medicare Learning Network, and provide to BCBSM, upon request, certificates of completion validating its compliance with the requirements set forth at 42 CFR 422.503(b)(4)(vi).

Provider shall allow BCBSM to maintain appropriate oversight of Provider's training efforts under its compliance plan as BCBSM maintains ultimate responsibility for compliance training. Provider shall maintain training records for a period of ten (10) years. Such records shall include attendance, topic, certificates of completion (if applicable), and test scores of any tests administered. Provider shall provide BCBSM and/or CMS with training logs and other materials related to training as requested by BCBSM and/or CMS.

3.21 **Compliance and FWA Concerns.** Provider shall, and shall require its Downstream Entities to, within five (5) business days of becoming aware of an actual, suspected, or potential compliance concern or actual, suspected, or potential fraud, waste, and abuse by Provider, Provider's Governing Body members, employees, contractors, agents, or Downstream Entities, report such compliance and FWA concerns to BCBSM. These reports may be made to the BCBSM Contract Administrator or by contacting the BCBSM Medicare Anti-Fraud Hotline at **(888) 650-8136 or TTY (800) 588-2711**. Reports may also be submitted to:

Fraud Investigations Unit
Blue Cross and Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Provider shall protect against retaliation for reporting of such compliance and fraud, waste, and abuse concerns. Provider shall ensure that these reporting requirements and its non-retaliation policy are well publicized. Provider shall coordinate with BCBSM to: (a) timely

investigate the compliance or FWA concern, (b) mitigate the compliance or FWA concern, and (c) implement appropriate corrective actions.

3.22 **Prompt Payment of Providers.** If Provider performs network contracting or otherwise is responsible for provider agreements, Provider shall ensure the provider agreements specify a prompt payment requirement, the terms and conditions of which are developed and agreed to by BCBSM and the contracted providers and suppliers.

3.23 **Audit Compliance**. Provider shall, and shall require its Downstream Entities to annually attest to compliance with the following paragraphs in the Agreement: 8.1(a) "No Adverse Actions or Investigations," 8.1(b) "No Criminal Conviction or Civil Judgments," 8.1(c) "No Excluded or Debarred Individuals," and 8.1(d) "Notice of Change of Circumstances." BCBSM reserves the right to audit Provider or Provider's Downstream Entities for compliance and/or to request verification that employees, contractors, Governing Body members, Downstream Entities, and major shareholders have been checked against the OIG and GSA Lists on at least a **monthly** basis. Provider agrees to provide BCBSM with any information necessary for BCBSM to conduct checks of the OIG and GSA Lists for Provider's employees, contractors, Governing Body members, Downstream Entities, and major shareholders (5% or more); or otherwise assist BCBSM in documenting compliance with this provision, including but not limited to, supplying attestations as required in this Section.

4. BCBSM'S OBLIGATIONS

4.1 **Compliance Responsibilities.** Notwithstanding any relationships that BCBSM may have with first tier, downstream, and related entities (including MA PPO Providers), BCBSM maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, and all applicable federal, state, and local laws, rules, and regulations, now or hereafter in effect including Medicare laws, regulations, reporting requirements, and CMS instruction. Provider acknowledges that BCBSM shall oversee and monitor Provider's performance on an ongoing basis.

4.2 **Continuation of Services.** Provider agrees that, in the event of BCBSM's insolvency or other cessation of operations, services to Members will continue through the period for which the CMS payment has been paid to BCBSM and services for Members who are hospitalized on the date BCBSM's contract with CMS terminates, or in the event of BCBSM's insolvency, through the date of discharge. BCBSM shall reimburse Provider for all services rendered pursuant to this section at Medicare allowable assignment rates minus any authorized Copayment, and Provider shall accept such payment as payment in full.

4.3 **Payment.** BCBSM shall reimburse Provider for rendering of Covered Services to Members. Such reimbursements will be paid as specified in one or more of the Exhibits or Attachments attached to this Agreement.

5. COMPENSATION

5.1 **Acceptance of Payment.** Provider shall accept as payment in full from BCBSM for rendering of Covered Services to Members, the compensation specified in one or more Attachments to this Agreement. Payment in full means there will be no subsequent

settlement for any provider type by BCBSM unless specifically provided for in another provision or Attachment of this Agreement

5.2 **Prompt Payment.** BCBSM shall promptly make payment on each timely Clean Claim forCovered Services rendered to a Member within thirty (30) days of receipt. All payments shall be made in accordance with BCBSM reimbursement policies. Claims paid beyond this time frame will be paid statutory interest commencing on the 31st day.

5.3 **Timely Submission of Claims.** Provider will file Clean Claims within one calendar year from the date of service or discharge, whichever is applicable. If the claim, including revisions or adjustments, is not submitted by Provider or Member within one calendar year from the date of service or discharge, benefits will not be paid. Claims, including revisions or adjustments, that are not filed by Provider prior to the claim filing limit of one calendar year from date of service or discharge will be the Provider's liability. Provider agrees to provide any additional information which is reasonably necessary to determine benefits and to verify performance under this Agreement.

5.4 **Provider Incentive Arrangements.** Any Provider payment arrangement pursuant to this Agreement, including any payment arrangement between Provider and a subcontractor, shall comply with all applicable requirements of the physician incentive regulations set forth by CMS.

5.5 **Refunds.** BCBSM shall have the right to recover amounts paid to Provider for services not meeting the applicable benefit or medical necessity criteria established by BCBSM, overpayments, services not documented in Provider's records, any services not received by Member, non-Covered Services, or for services furnished when Provider's license was lapsed, restricted, revoked, or suspended. BCBSM shall have the right to initiate recovery of amounts paid for services up to twenty-four (24) months from the date of payment. In instances of fraud, there will be no time limit on recoveries.

5.6 **Non-Covered Services.** No benefits are payable pursuant to this Agreement which are not otherwise payable by Member's MA PPO Benefit Contract.

5.7 **Services Rendered by Non-Physician Providers.** Compensation shall only be paid to those non-physician providers who are (1) supervised by a physician who is a contracted physician in the MA PPO network and (2) authorized under original Medicare to provide services to Beneficiaries.

BCBSM shall determine, in its sole discretion, the standards of supervision to which supervising physicians must adhere. These standards will be published in the BCBSM MA PPO Provider Manual.

6. TERM AND TERMINATION

6.1 **Term and Termination.** The Initial Term of this Agreement shall begin on the Effective Date and expires at the end of the calendar year of the Effective Date. Thereafter, this Agreement shall automatically renew for successive one (1) year periods unless terminated by either party at any time upon sixty (60) days prior written notice to the other.

6.2 **Termination of MA PPO Program.** This Agreement shall terminate immediately upon the official cancellation of BCBSM's contract with CMS or on the official date of discontinuance of BCBSM's MA PPO Program, whichever is earlier.

6.3 **BCBSM Immediate Termination.** This Agreement shall immediately terminate upon notice to Provider upon any of the following events:

a. any adverse action resulting in Provider's exclusion from participation in federal health programs;

b. Provider's authority to do business in Michigan is revoked, suspended, or restricted by any action, including probation or any compliance agreements, by the Michigan Department of Community Health or other governmental agency;

c. fraud by Provider;

d. Provider pleads guilty or *nolo contendere* to or is convicted of any crime, or is placed in a diversion program relating to the payment or provision of health care;

e. imminent harm to a Member's health;

f. Provider has an exclusive relationship with another payor;

g. Provider fails to meet or demonstrate applicable credentialing and re-credentialing criteria, standards or requirements established by BCBSM;

h. BCBSM departicipates Provider from the BCBSM Traditional Program;

i. any cancellation or material modification of Provider's professional liability insurance.

6.4 **Termination for Breach.** In addition to the specific grounds for termination set forth in 6.3, Provider agrees that BCBSM, consistent with its obligations under the MA program, may terminate this Agreement if Provider does not perform satisfactorily or if any of Provider's reporting and disclosure obligations are not fully met in a timely manner. To that end, BCBSM may terminate this Agreement for any breach of the Agreement by Provider upon at least thirty (30) days prior written notice, unless such breach is cured to the satisfaction of BCBSM within such thirty (30) day period.

6.5 **Notice to Provider.** If BCBSM suspends or terminates this Agreement, BCBSM must give affected Provider individual written notice of the following: (i) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate Providers and the numbers of Providers needed by BCSBM; and (ii) affected Provider's right to appeal the action and the process and timing for requesting a hearing.

6.6 **Provider Immediate Termination.** Provider may terminate this Agreement immediately in the event that:

a. BCBSM's certificate of authority or license to operate is suspended, revoked, or limited;

b. BCBSM fails to maintain adequate levels of insurance;

c. A judgment of civil liability or a criminal conviction (including a plea of *nolo contendere*) for Medicare or Medicaid fraud or similar offense involving health insurance fraud, revocation, or suspension of participation in Medicare or Medicaid, or conviction (including a plea of *nolo contendere*) of a felony or of a misdemeanor involving fraud or moral turpitude is rendered against BCBSM.

6.7 **Provisions Surviving Termination.** The provisions of Sections 3.7, 3.8, 3.10, 3.13, 4.2, and 8.11 shall survive any termination of this Agreement.

7. MODIFICATIONS

7.1 **Regulatory or Policy Changes.** BCBSM may unilaterally amend this Agreement or its policies and procedures at any time to comply with changes in regulatory and policy requirements affecting BCBSM and/or Provider related to BCBSM's MA PPO Program by providing written or electronic notice of any such amendment to Provider along with the effective date of the amendment. Electronic notice shall include, but not be limited to, publication on web-DENIS. Written notice may include publication in *The Record*. BCBSM shall use its best efforts to provide such written notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Unless otherwise required by federal or state regulatory authorities, the signature of Provider shall not be required for any such amendment.

7.2 **Change in the MA PPO Provider Manual.** BCBSM will not modify the MA PPO Provider Manual without thirty (30) days prior written or electronic notice to the Provider. Electronic notice shall include but not be limited to publication on web-DENIS. Written notice may include publication in *The Record*.

7.3 **General Modifications.** BCBSM may amend this Agreement by providing ninety (90) days prior notice, written or electronic, of such amendment. Electronic notice shall include, but not be limited to, publication on web-DENIS. Written notice may include publication in *The Record*. Provider's signature is not required to make the amendment effective. However, should the Provider no longer wish to continue affiliation in the MA PPO Program because of an amendment, then Provider may terminate this Agreement by providing forty-five (45) days written notice to BCBSM except during the initial term of the Agreement.

Otherwise, this Agreement, or any part, article, section, Exhibit, or Attachment hereto, may be amended, altered, or modified only in writing as duly executed by both parties.

8. GENERAL PROVISIONS

8.1 **Provider Representations and Warranties.** Provider warrants that Provider is duly qualified and approved to act as a provider of health care services to Beneficiaries under

Title XVIII of the Social Security Act. Further:

a. **No Adverse Actions or Investigations**. Provider asserts that, to the best of its knowledge, information and belief, there are no past or pending investigations, legal actions, or matters subject to arbitration involving Provider nor any of its employees, contractors, Governing Body members (as defined in Chapter 21 of the CMS Medicare Managed Care Manual) members, or any major shareholders (5% or more) on matters relating to payments from governmental entities, both federal and state, for health care and/or prescription drug services.

b. **No Criminal Convictions or Civil Judgments**. Provider asserts that, to the best of its knowledge, information and belief, neither Provider nor any of its employees, contractors, Governing Body members, or any major shareholders (5% or more) have been criminally convicted or had a civil judgment entered against them for fraudulent activities, nor are they sanctioned under any Federal program involving the provision of heath care and/or prescription drug services.

c. **No Excluded or Debarred Individuals**. Provider asserts that, to the best of its knowledge, information and belief, neither Provider nor any of its employees, contractors, Governing Body members, or any major shareholders (5% or more) appears on the List of Excluded Individuals/Entities as published by HHS Office of the Inspector General, nor on the list of debarred contractors as published in the System for Award Management by the General Services Administration (GSA List).

   Provider agrees that it will review the OIG List and the GSA List prior to the hiring of any new employees, contractors, or Governing Body members. Provider also agrees that is shall, on a monthly basis, for all employees, contractors, Governing Body members, Downstream Entities, and major shareholders (5% or more) review the OIG and GSA Lists to ensure that none of these persons or entities are excluded or become excluded from participation in Federal programs.

d. **CMS Preclusion List.** Medicare Advantage Organizations are not permitted to make payment for a health care item, service, or drug that is furnished, ordered or prescribed by an individual or entity that is included in the CMS Preclusion List 42 C.F.R. § 422.2. Should Provider be added to the CMS Preclusion List, it agrees to immediately notify BCBSM so that BCBSM may notify its impacted members. Provider understands and agrees that beginning 60 days after the notification to the member, Provider will no longer be eligible for payment from BCBSM and will be prohibited from pursuing payment from the member for any service furnished, ordered, or prescribed after that date. Provider also understands and agrees that it will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after the 60-day period. Provider asserts that it does not now, nor will it in the future, employ or contract with providers or prescribers who are listed on the CMS Preclusion List. Provider understands that the Preclusion List will be regularly updated by CMS and agrees that it will monitor the Preclusion List and ensure that none of its employees, contractors, or prescribers are included on it. Should Provider discover that one of its employees, contractors, or prescribers has been added to the preclusion list, Provider agrees to immediately notify BCBSM. Provider shall ensure that payments are not made to providers or prescribers included on the CMS Preclusion List. To the extent that Provider contracts with other providers to provide services to BCBSM members pursuant to this

agreement, it will require such other providers to comply with the requirements of 42 C.F.R. § 422.2 and 42 C.F.R. § 422.222.

e. **Notice of Change of Circumstances**. Provider is obligated to notify BCBSM immediately of any change in circumstances occurring after the effective date of this Agreement which would require Provider to then respond affirmatively to any of the statements in subsections a. – d.

8.2 **Delegation.** BCBSM may only delegate activities or functions to Provider in a manner consistent with CMS rules and regulations. BCBSM has delegated to Provider the activities and reporting responsibilities set forth in the applicable and legally binding master agreement(s) and exhibits, and/or other contracts, if any. Provider shall require its Downstream Entities (as defined by CMS in 42 CFR 422, *et seq*.) to provide reasonable assurance as evidenced by written contract that such subcontractor, agent, or other Downstream Entity shall comply with the same Medicare Advantage program requirements and obligations that are applicable to Provider under this Agreement. Provider shall monitor and audit its Downstream Entities to ensure that they are in compliance with all applicable laws, regulations, and contractual requirements, including compliance with the Medicare Advantage provisions in this Agreement. If Provider determines that its Downstream Entities require corrective action(s), Provider shall ensure that such corrective action(s) is taken by Downstream Entity. Provider shall provide information about its Downstream Entity oversight, including any corrective actions plans, to BCBSM upon request. BCBSM shall be responsible for overseeing and is ultimately accountable for the performance of Provider and Downstream Entities with regard to delegated responsibilities described in this Section. Processes for performing delegated administrative responsibilities shall be reviewed, preapproved and monitored by BCBSM on an ongoing basis. Provider shall participate in and comply with BCBSM's oversight program, including but not limited to, attending meetings; providing attestations; responding to document, policy, and procedure review requests; implementing corrective action plans suggested by BCBSM or CMS; participating in monitoring reviews; and providing BCBSM with similar information about Provider's Downstream Entities. If Provider or a Downstream Entity fails to perform delegated services, reporting or disclosure responsibilities in a manner satisfactory to BCBSM or CMS, BCBSM shall retain the right to revoke such delegation in accordance with Termination for Cause provisions set forth herein.

8.3 **Provider's Agreements with Downstream Entities**. To the extent that Provider delegates any responsibilities under the terms of this Agreement, such delegation shall be set forth in a separate written agreement that shall include the following requirements:

(i) Written arrangements must specify delegated activities and reporting responsibilities.

(ii) Written arrangements must provide for revocation of the delegation activities and reporting requirements in instances where CMS or BCBSM determine that such parties have not performed satisfactorily.

(iii) Written arrangements must specify that the performance of the parties is monitored by BCBSM on an ongoing basis.

(iv) Written arrangements must specify that either:

(A) The credentials of medical professionals affiliated with the party or parties will be either be reviewed by BCBSM; or

(B) The credentialing process will be reviewed and approved by BCBSM, and BCBSM must audit the credentialing process on an ongoing basis.

(iv) All contracts or written arrangements must specify that the Downstream Entity must comply with all applicable Medicare laws, regulations, reporting requirements, and HHS/CMS instructions.

8.4 **Relationship of the Parties.** The relationship of the parties is not and shall not be construed or interpreted to be a relationship of employer and employee, partnership, joint venture or agency. The relationship between the parties is an independent contractor relationship.

8.5 **Full Force and Effect.** In the event any provision of this Agreement is rendered invalid or unenforceable, the remainder of the provisions of this Agreement shall remain in full force and effect.

8.6 **Assignability.** No assignment of the rights, duties or obligations under this Agreement shall be made by either party without the written approval of the other party.

8.7 **Waiver.** Neither the failure nor any delay on the part of either party to exercise any right, power, or privilege hereunder shall operate as a waiver.

8.8 **Proprietary Information.** The parties agree that the terms and conditions of this Agreement, including any Attachments and Exhibits, are proprietary, and agree to take all reasonable precautions to prevent the unauthorized disclosure of the terms.

8.9 **Non-exclusive Agreement.** Nothing contained in this Agreement shall preclude Provider from participating in or contracting with any other preferred provider organization, health maintenance organization, insurer or payer of health services or other health delivery or insurance program whether before, during or subsequent to the terms of this Agreement.

8.10 **Independent Corporation.** The Provider hereby expressly acknowledges the understanding that this Agreement constitutes a contract between Provider and BCBSM, that BCBSM is an independent nonprofit corporation operating under a license with the Blue Cross Blue Shield Association ("BCBSA"). The Provider further acknowledges and agrees that he or she has not entered into this Agreement based upon representations by any person other than BCBSM, and that no person, entity, or organization other than BCBSM shall be held accountable or liable to the Provider for any of BCBSM's obligations to the Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSM other than those obligations created under other provisions of this Agreement.

8.11 **Indemnification.** Each party shall indemnify and hold the other parties harmless for any

claims, losses, damages, liabilities, costs, expenses or obligations arising out of or resulting from any act or omission by that party or any of that parties associated employees or agents in performing its responsibilities pursuant to the terms of this Agreement, or arising from their criminal, fraudulent, negligent, or dishonest acts or omissions.

The parties agree that neither they nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other party.

BCBSM may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify BCBSM against any civil liability for damage caused to a Member as a result of the BCBSM's denial of medically necessary care: (a) a physician or health care professional; (b) Provider; (c) other entity providing health care services; or (d) group of such professionals, providers, or entities.

8.12 **Governing Laws.** This Agreement shall be governed by the laws of the state of Michigan or the laws of the federal government, whichever is applicable. In addition, any provision of this Agreement which does not conform to the laws of Michigan or the United States is amended to conform to their minimum requirements.

8.13 **Severability.** To the extent any provision of this Agreement is prohibited by or invalid under applicable law or determined invalid or unenforceable by a court of competent jurisdiction or any other governmental authority with jurisdiction over the parties hereto, such provision shall be ineffective to the extent of such prohibition, invalidity or unenforceability without invalidating the remainder of the provision or the remaining provisions of this Agreement.

IN WITNESS WHEREOF, the parties, wishing to be bound by the terms and conditions of this Agreement, have affixed their signatures on the separate signature page entitled "Signature Document" which is incorporated herein by reference.

A scanned, imaged, electronic, photocopy, or stamp of the above signatures shall have the same force and effect as an originally executed signature.