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HEALTH PLAN OBLIGATIONS

(To be included as an Amendment to the State's Medicaid Contract with Health Plans)

This obligation shall apply where a Health Plan does not have a contract with a Hospital to provide services to the Health Plan's Medicaid beneficiaries and where Hospital has signed a Hospital Access Agreement with the Michigan Department of Community Health ("Department").

The Health Plan will make efforts to utilize network-contracted services where appropriate.

The Health Plan may deny any claims submitted later than 180 days from the date of service for the first year of this agreement and 120 days the second year and thereafter. The submission requirement shall not apply in the event of exceptions that extend the time period. Exceptions granted by the Health Plan may be for changes in eligibility, coordination of benefits, other third party payer issues, internal Hospital risk management, or other valid reasons which may have delayed the submission of a claim.

When the Hospital requests a billing extension, the Health Plan agrees to evaluate the information supplied and provide the Hospital with an extension when appropriate based on exceptions noted above. Under no circumstances will the Health Plan accept any claim that is submitted more than 365 days from the date of service.

Authorization Requests—Post Stabilization

The Hospital will make and document all post-stabilization authorization inquiries by telephone call to the Enrollee's Health Plan. The Health Plan will return all post-stabilization inquiries within one hour of receipt of the telephone call from the Hospital and the Hospital shall not be required to make more than one call provided that the "one phone call" included clinical information. **Authorization for admission and additional services shall be automatic should the Health Plan fail to respond within one hour.** The Hospital agrees to provide the Health Plan with requested information obtained from a "medical screening examination," provided in accordance with EMTALA, in order to determine the emergent status for payment approval, prior to treatment and after stabilization. The Health Plan shall provide twenty-four (24) hour, seven (7) day a week availability for post-stabilization authorization requests.

Disputed Claims

Each Health Plan and Hospital that serves or has a contract to serve the same population of Medicaid beneficiaries will establish an Accounts Receivable Reconciliation Group (ARRG) comprised of persons empowered to make decisions regarding outstanding bills and payments. The ARRG shall reconcile accounts receivable of the Hospital with accounts payable of the Health Plan. These groups will minimally meet no less than every 90 days.

Claims in dispute by either the Hospital or the Health Plan will be forwarded to the Accounts Receivable Reconciliation Group. The group can table claims in question for one 90-day period before either resolving the claim or referring it to the Rapid Dispute Resolution Process. If agreement cannot be reached on the payment after review by the ARRG, the Hospital or Health Plan may pursue dispute resolution as set forth in the Rapid Dispute Resolution Process. If either the Hospital or Health Plan pursues Rapid Dispute Resolution Process, that determination is then binding on the other party. The claims forwarded to the Rapid Dispute Resolution Process may either be a single claim or may be a group of similar claims. The determination of claim similarity will be made by the mediator during the Rapid Dispute Resolution Process.

Payment

- Forty-five Day Payment. The Health Plan shall pay Hospital's Clean Claims within forty-five (45) days after receipt.

- Thirty-Day Denial/Additional Information Notice. The Health Plan shall provide the Hospital with a denial or written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient claim. The Health Plan may either deny the claim or make payment in full to the Hospital within thirty (30) days on a "corrected" claim.

- Adjusted Payment. The Health Plan may make an Adjusted Payment on a submitted claim within forty-five (45) days after receipt, where the totality of circumstances do not support the billing criteria for the level of service submitted on the claim, and may remit or recover such Adjusted Payment, providing a full and complete explanation and remittance advice. Where such Adjusted Payment is made, the Hospital may dispute the adjustment, and pursue any and all remedies, including the Rapid Dispute Resolution Process or OFIS appeal process, or other remedies of law.

- Payment and Remedies. Payment for services by a Health Plan shall be made as set forth in this document, and any disputed claim aged over 90 days shall give rise to the right of the Hospital to pursue the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process. Any award rendered pursuant to the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process shall be made by the Health Plan within 30 days after its receipt of a final decision, or withheld by the Department from the Health Plan's capitation and paid to the Hospital within 30 days after the Department's receipt of a final decision.

- Rates. The Health Plan shall pay the Hospital according to Medicaid Rates.

- Post Payment Review. The Health Plan may implement a post-payment claim review process in accordance with Department policies.

Department Payment

The Department will deduct from future capitations and make payment to the Hospital for provision of Covered Services under the following conditions:

- The Health Plan does not pay the Hospital the amount to which the Hospital is entitled for services described in "Provision of Covered Services" (Section 1.1 of Hospital Access Agreement, Attachment A) at the time such payment is required to be paid; and
- The disputed claim has been reviewed by the Accounts Receivable Reconciliation Group, (ARRG) described above, and the Hospital has either, (i) forwarded the disputed claim to the Rapid Dispute

Resolution Process (Attachment C) mediator, (ii) initiated an OFIS appeal process, or (iii) initiated another applicable legal process; and

- A final decision that the Hospital is entitled to payment has been rendered through either the Rapid Dispute Resolution Process, the OFIS appeal process, or other applicable legal process; and
- The Health Plan does not pay the disputed claim within 30 days of its receipt of the final decision.

Data Coordination

The Health Plan and the Hospital will share enrollee information in order to support claims payment administration, to enable coordination of benefits, subrogation, verification of coverage, prior authorization and record keeping.

Quality, Utilization and Risk Management (Q/U/RM)

The Health Plan and Hospital shall coordinate Q/U/RM services required in connection with patient care to the extent required by applicable state and federal law or accrediting entities. The Health Plan shall acknowledge that the information it receives as a result of participating in Q/U/RM activities with the Hospital is, and shall remain, confidential as required by applicable law, and is furnished to the Health Plan solely to assist the Health Plan in conducting its own professional practice review. The Health Plan will reimburse the Hospital for reasonable photocopy expenses incurred by the Hospital in conducting the Q/U/RM review. The Health Plan may disclose confidential Q/U/RM information to third parties as necessary to (i) satisfy mandatory governmental or regulatory reporting requirements, (ii) for HEDIS reporting, (iii) for reporting required by applicable accrediting bodies.

Orderly Transfer

The Health Plan shall cooperate with the Hospital in the orderly transfer of Enrollees being treated or evaluated to a contracted Hospital provider, in the event that the Plan or physician elects to transfer the Enrollee to another Hospital facility. In the event that services or care are required for any Enrollee while awaiting transfer, or within the context of preparation for the transfer, the Health Plan and the Hospital agree to share such information as may be required. The Health Plan shall authorize payment for services, such as observation costs, in order to facilitate the orderly transfer and maintain the stability and health of the Enrollee. To the extent practicable, transfers to other hospitals should occur within 24 hours of the request of the Health Plan to the extent practicable.