See the Medicaid Provider Manual, Hospital Chapter, Hospital Reimbursement Appendix, Section 4 for background on this document. The document was originally issued as part of MSA 01-28.

Hospital Access Agreement

This Agreement is made between the Michigan Department of Community Health ("Department"), _____ and _____, a hospital licensed under the laws of the State of Michigan ("Hospital"). This Agreement shall apply where Hospital provides services to Medicaid beneficiaries who are enrolled in a Health Plan with which Hospital does not have a contract. Where Hospital and a Health Plan have a contract, the terms of that contract shall govern each relationship, and this Agreement shall not apply. When Hospital and a Health Plan have a limited services contract, the Agreement shall apply for all covered services outside the scope of the limited services contract. Since this is not a contract between hospitals and health plans, it is expected that health plans will continue to use network contracted providers where appropriate.

This Agreement is based on the following principles:

A. This Agreement is intended to provide access for all Covered Services that are available at Hospital for all Medicaid enrolled beneficiaries, and to provide for the payment and billing policies and procedures for those services, where Hospital and the Enrollee's Health Plan have not entered into a contract.

B. The parties believe that it is essential to encourage contracting as the preferred relationship between Health Plans and Hospitals, and to preserve the freedom of contract between Hospitals and Health Plans.

C. Hospital will be entitled to payment by a Health Plan for all Covered Services provided in accordance with this Agreement, at Medicaid Rates.

D. In the event a Health Plan does not make the payment to Hospital that is required under this Agreement, the Department will deduct the unpaid amount from future Health Plan capitation payments and shall make such payment to Hospital in accordance with this Agreement.

E. The Department shall cause the contracts between the State and each Health Plan to include a provision that each Health Plan will comply with the terms of this Agreement.

1.1 Provision of Covered Services. Hospital agrees to provide or arrange for Medically Necessary Covered Services to Medicaid beneficiaries who are enrolled in a Health Plan with which Hospital does not have a contract where:

i. Emergent services are required to be provided by the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd ("EMTALA"); or

ii. Elective Admissions and Services (not required to be provided by EMTALA) have been arranged by a physician who has admitting privileges at Hospital, where beds, services and adequate resources are available, and Authorization for the Elective Admissions and Services have been obtained from the Health Plan.

In the case of Elective Admissions and Services, Health Plans will make efforts to utilize network contracted services where appropriate. It is the responsibility of the Health Plan to direct beneficiaries to network providers.

1.2 Health Plan Payment. Under this agreement Health Plans will pay Hospital at Medicaid Rates for all Covered Services provided by Hospital to Medicaid beneficiaries who are enrolled in Health Plans.

1.3 Department Payment. In the event that (i) a Health Plan does not pay to Hospital the full amount to which Hospital is entitled for services described in Section 1.1 above, and (ii) a final decision that Hospital is entitled to payment has been rendered through the Rapid Dispute Resolution Process, or through the OFIS appeal process, or through any other legal process, the Department will deduct the unpaid amount from future Health Plan capitation payments and pay it to Hospital. The Department will initiate the capitation deduction within 30 days after receipt of a final decision that payment was not made as required by this Agreement.

1.4 Authorization Requests—Post Stabilization. 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 Hospital and 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.** 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.

1.5 Prior Authorization—Elective Admissions and Services. All Elective Admissions and Services must have Prior Authorization from the Health Plan. Prior Authorization by a Health Plan shall not prevent the Health Plan from a retrospective evaluation of medical services provided by Hospital. The granting of Prior Authorization for Covered Services by a Health Plan shall create a presumption that Medically Necessary services appropriate to the diagnosis presented at the time of Prior Authorization shall be paid pursuant to this Agreement. A Health Plan shall be required to support denial of payment for Prior Authorized services.

1.6 Data Coordination. Hospitals and Health Plans 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.

1.7 Quality, Utilization and Risk Management (Q/U/RM). Hospital and the Health Plan 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 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 Hospital for reasonable photocopy expenses incurred by 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.

1.8 Orderly Transfer. Hospital shall cooperate with the Health Plan in the orderly transfer of Enrollees being treated or evaluated to a contracted hospital provider, in the event that the Health 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 transfer, the Health Plan and 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. Transfers to other hospitals should occur within 24 hours of the request of the Health Plan to the extent practicable.

1.9 Claims.

1.9.1 Hospital shall provide claims in compliance with billing format UB-92 or other successor formats for Hospital services and billing format HCFA 1500 or other successor formats for professional services and as further outlined in Medicaid policies. Hospital will submit claims for Covered Services within 180 days from the date of service during the first year of this agreement and 120 days thereafter. The requirement shall not apply in the event of exceptions that extend the time period for the submission of claims. Exceptions granted by the Health Plans 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. Under no circumstances will any claim be submitted later than 365 days from the date of service.

1.9.2 Hospital agrees to pursue other available resources, i.e., other insurance coverage, prior to submitting claims to a Health Plan. If Hospital has submitted a claim to another resource but has not received payment, and the billing deadline is near, Hospital agrees to contact the Health Plan to request a billing extension or to obtain approval from the Health Plan to submit a timely claim and a claim adjustment following adjudication by the other resource.

1.9.3 If Hospital is unable to comply with the billing time frame for another reason, e.g., an internal risk management issue, Hospital must contact the Health Plan to explain the circumstances and request a billing extension. Health Plan shall not unreasonably deny such an extension.

1.10 Disputed Claims.

1.10.1 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 Hospital with accounts payable of the Health Plan. These groups will meet no less than every 90 days.

1.10.2 Claims in dispute by either Hospital or the Health Plan will be forwarded to the ARRG. The ARRG can table claims in question for no more than 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, Hospital or the Health Plan may pursue dispute resolution pursuant to the Rapid Dispute Resolution Process. If either the Health Plan or Hospital pursues the Rapid Dispute Resolution Process, that determination is 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.

1.10.3 Payment.

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

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

iii. **Adjusted Payment.** A 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, 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**.**

1.11 **Enrollee Hold Harmless.** Hospital will not bill Medicaid beneficiaries enrolled in Health Plans for any Covered Services. Hospital shall look only to the Health Plan, other third party payers, and the Department to the extent provided under this Agreement, for compensation for Covered Services rendered to an Enrollee when the Health Plan covers such services, in accordance with Department policy and federal and state law.

1.12 **Termination.** Either party may cancel this Agreement without cause on 90 days' advance written notice.

1.13 **Parties to This Agreement.** The parties to this Agreement are Hospital and the Department. The Department agrees that it will enter into an agreement with each Health Plan and require the Health Plan to comply with the provisions of Attachment B of this bulletin. The Hospital Access Agreement is not a contract between a hospital and health plan.

1.14 **Governing Law.** This Agreement will be governed by the terms of Michigan Law.

1.15 **Notice of Change.** The Department shall provide advance notice to each Hospital that has signed the Hospital Access Agreement of any change to defined terms included as Attachment D to this bulletin. The advanced notice shall be consistent with the process and timeframe used for Medicaid policy promulgation, as outlined in MCL 400.111a and which is not otherwise prohibited under federal and state law.

This Agreement shall become effective on the signature of both parties to this Agreement or a facsimile copy of this Agreement.

For Hospital:

Hospital Name

Signature **Title**

Printed Name **Date**

For Department of Community Health:

Signature **Title**

Printed Name **Date**