BCN ADVANTAGE AMENDMENT

TO

INDIVIDUAL PROVIDER AFFILIATION AGREEMENT

This amendment **(Amendment)** to the Individual Provider Affiliation Agreement **(Agreement)** by and between **Blue Care Network of Michigan, Blue Care of Michigan, Inc. and BCN Service Company** (hereinafter collectively referred to as **Health Plan**) and **_____ (Provider)** shall be effective **_____**.

The following sections shall be added to the Agreement under a new Article: **Medicare Advantage Provisions**. In the event of a conflict between this Amendment and language contained elsewhere in the Agreement, the provisions of this Amendment shall take precedence and supersede.

1. **Medicare Advantage Member or MA Member** - A Member who is eligible for Medicare and who is enrolled with Health Plan under a contract (Medicare Advantage Contract) between Health Plan and the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS).

2. **Credentialing** - Provider shall satisfy all credentialing and re-credentialing criteria, standards and policies established by Health Plan and/or CMS, as may be amended from time to time. Applicable credentialing standards include maintenance of acceptable levels of any medical liability insurance. Health Plan retains sole discretion to determine whether Provider qualifies for affiliation under Medicare Advantage in accordance with applicable criteria, standards and policies.

3. **Medical Records** - Provider shall maintain accurate and timely medical records for MA Members treated by Provider in accordance with applicable federal and state laws and regulations. Such records shall be maintained for at least ten (10) years after the final date of this Amendment or completion of audit, whichever is later. Provider shall safeguard the confidentiality of MA Member information in accordance with applicable CMS and Health Plan requirements and other federal, state and local laws, rules and regulations including but not limited to HIPAA.

4. **Access to Records** - Provider shall permit any authorized local, state, or federal government agency, including without limitation Health Plan, the U.S. Department of Health and Human Services (HHS), U.S. General Accounting Office (GAO), Centers for Medicare and Medicaid Services (CMS), the Comptroller General, and their designees to audit, evaluate, or inspect any books, contracts, records, including medical records, patient care documentation, and other records of Provider, related entities and downstream delegates that pertain to Health Plan's Medicare Advantage Contract with CMS. Provider shall provide such information to Health Plan as shall be necessary to comply with reporting requirements established by CMS. Such access shall be permitted for up to ten (10) years after the final date of this Amendment or completion of audit, whichever is later.

5. **MA Member Hold-Harmless** - Except in the event that MA Member has primary coverage with another carrier or third party payer and except for applicable Copayments or Deductibles, Provider agrees to look solely to Health Plan for payment for Covered Services rendered under the Agreement and to accept payment made in accordance with the Agreement as payment in full. Provider will in no event, including but not limited to nonpayment, insolvency or breach of the Agreement, bill, charge, collect a deposit from, seek payment from, maintain any action at law or in equity or have any other recourse against a MA Member or person (other than Health Plan) acting on behalf of Member for Covered Services provided pursuant to the Agreement. Provider is also prohibited from holding MA Members liable for Medicare Parts A and B cost-sharing that are the legal obligation of Health Plan or the State; or payment of any fees that are the legal obligation of the Health Plan. This provision does not prohibit Provider from collecting charges for supplemental benefits or Copayments or Deductibles, where appropriate, or for non-Covered Services delivered on a fee-for-service basis to MA Members who are informed in advance of their payment responsibility and the estimated charges. This provision shall survive termination of the Agreement for Covered Services rendered prior to termination regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the MA Member. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and MA Member or person acting on Member's behalf, insofar as such contrary agreement relates to liability for payment of Covered Services provided under the Agreement.

6. **Obligations of Recipients of Federal Funds** – Provider acknowledges that payments to Provider pursuant to this Amendment are made, in whole or in part, from federal funds and that this Amendment is subject to all laws applicable to entities and individuals receiving federal funds. Provider shall comply with all requirements of laws applicable to recipients of federal funds, including the False Claims Act (32 USC 3729, et seq.), the Anti-Kickback Statue (section 1128B(b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

7. **Provider Responsibilities** - Provider shall perform responsibilities under the Agreement on behalf of MA Members in accordance with applicable Medicare laws, regulations, CMS instructions, Health Plan policies and procedures, and requirements set forth in the Medicare Advantage Contract between CMS and Health Plan.

8. **Compliance with Health Plan's Contractual Obligations**– Provider agrees that services performed under the Agreement will be consistent and comply with Health Plan's contractual obligations with CMS. 42 CFR 422.504(i)(4).

9. **Selection of Affiliated Providers**– To the extent Health Plan delegates the selection of Affiliated Providers to Provider, Health Plan retains the right to approve, suspend, or terminate such arrangement. 42 CFR 422.504(i)(5)

10. **Prompt Payment of Affiliated 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 Health Plan and the contracted providers and suppliers.

11. **Medical Management and Quality Improvement Program**– Provider shall participate in Health Plan's quality improvement, performance improvement, and/or medical management programs. Provider shall also participate in CMS and 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 BCN Advantage Program, Provider shall cooperate with Health Plan's quality assurance, drug utilization management and medication therapy management programs, and shall support e-prescribing.

12. **Claims Adjudication** - Covered Services provided by Provider to MA Members shall be paid at the lesser of billed charges or the applicable BCN Advantage Behavioral Health Professional Fee Schedule in effect on the date of service, less applicable Copayments. Covered Services not listed on the designated Fee Schedule will be paid at 65% of billed charges, less applicable Copayments. Health Plan or its designee shall receive, process and pay in a timely manner claims for Covered Services rendered by Provider in accordance with the authorization procedures as set forth in the Provider Manual. Health Plan shall ensure that Clean Claims are adjudicated promptly in accordance with applicable statutory and regulatory requirements. Health Plan will adjudicate all Clean Claims within forty-five (45) days following receipt from Provider. Simple interest on Clean Claims not timely paid will be computed at the rate of 12% per annum.

13. **Encounter/Claims Data and Certification of Accuracy** - Provider shall submit to Health Plan all data necessary to characterize the context and purposes of each encounter between Provider and an MA Member and to facilitate claims adjudication in accordance with applicable CMS encounter reporting requirements. If Provider generates data to determine payment on behalf of Health Plan, the Provider must certify (based on best knowledge, information and belief) the accuracy, completeness and truthfulness of such data.

14. **Continuation of Benefits** - Provider agrees that, even in the event of insolvency or other cessation of operations by Health Plan, Provider will continue to provide Covered Services to MA Members through the period for which Member's applicable premium has been paid and, for MA Members who are hospitalized on the date Health Plan's contract with CMS terminates, or in the event of Health Plan's insolvency, through the date of discharge. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and MA Member or person acting on Member's behalf, insofar as such contrary agreement relates to liability for payment of Covered Services provided under this continuation of benefits provision.

15. **No Adverse Actions or Investigations** - Provider asserts that, to the best of their knowledge, information and belief, there are no past or pending investigations, legal actions, or matters subject to arbitration involving Provider, or any of Provider's employees, contractors, Governing Body (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 healthcare and/or prescription drug services.

16. **No Criminal Convictions or Civil Judgments** - Provider asserts that, to the best of their knowledge, information and belief, neither Provider nor any of Provider's 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 health care and/or prescription drug services.

17. **No Excluded or Debarred Individuals** - Provider asserts that, to the best of their knowledge, information and belief, neither Provider, nor any of Provider's employees, contractors, Governing Body members, or any major shareholders (5% or more) appear in the List of Excluded Individuals/Entities as published by the Office of the Inspector General, and/or in 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 it 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.

18. **Notice of Change of Circumstances** - Provider is obligated to notify Health Plan immediately of any change in circumstances occurring after the effective date of this Amendment which would require Provider to then respond affirmatively to any of the questions posed in Sections 15-17.

19. **Corrective Actions** - Provider shall document and take appropriate corrective actions in response to any potential noncompliance or potential Fraud, Waste and Abuse (FWA) identified via audit, monitoring, or otherwise, by Health Plan, HHS, GAO, or CMS. Provider shall allow Health Plan, HHS, GAO, and/or CMS to oversee their documentation and implementation of corrective actions.

20. **CMS Risk Adjustment Data Validation Audit** - Provider will include supporting documentation in a MA Member's medical record for all diagnosis codes submitted by Provider to Health plan 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 his or her obligation to cooperate with Health Plan and/or CMS during such audits and to timely produce requested medical records in accordance with 42 CFR 422.310(e). Provider also agrees to produce attestations upon request by Health Plan to correct signature deficiencies in the medical record.

21. **Compliance Plan** - Provider shall have a compliance plan that includes: (1) measures to detect, correct, and prevent fraud, waste, and abuse; (2) written policies, procedures, and standards of conduct articulating its 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 fraud, waste, and abuse; (5) effective lines of communication between the compliance officer and Health Plan, 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's compliance and Fraud, Waste, and Abuse (FWA) training program shall address at a minimum these subject matters:

    A. Description of the compliance program;

    B. How employees, Governing Body members, and Downstream Entities should ask compliance questions, including emphasizing confidentiality, anonymity, and non-retaliation for compliance related questions or reports of suspected or detected noncompliance or potential FWA;

C. Requirement to report actual or suspected Medicare program noncompliance or potential FWA;

D. Examples of reportable noncompliance and FWA that employees, Governing Body members, and Downstream Entities might observe;

E. Review of the disciplinary guidelines for non-compliant or fraudulent behavior;

F. Attendance or participation in compliance and FWA training programs as a condition of continued employment;

G. Review of compliance, FWA, and other policies related to contracting with the government;

H. Review of potential conflict of interest and Provider's system for disclosure of conflicts of interest;

I. Overview of Health Insurance Portability and Accountability Act of 1996, as amended, the Health Information Technology for Economic and Clinical Health (HITECH), and CMS Data Use Agreement (if applicable);

J. Overview of the monitoring and auditing process; and

K. Review of the laws that govern employee conduct in the Medicare program (i.e., False Claims Act, Anti-kickback statute, HIPAA/HITECH, etc.).

Provider shall allow Health Plan to maintain appropriate oversight of Provider's training efforts under the Provider's compliance plan as Health Plan maintains ultimate responsibility for compliance training. Provider shall attest to Health Plan annually that they meet the requirements identified in this Section and has conducted compliance training in accordance with its compliance plan. 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 Health Plan and/or CMS with training logs and other materials related to training as requested by Health Plan and/or CMS.

22. **Compliance and FWA Concerns** - Provider shall, and shall require their 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 Health Plan. These reports may be made to the Health Plan Contract Administrator or by contacting the Health Plan Medicare Anti-Fraud Hotline at **(888) 650-8136 or TTY (800) 588-2711**. Reports may also be submitted to:

Fraud Investigations Unit
Blue Cross 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 Health Plan to: a) timely investigate the compliance or FWA concern, (b) mitigate the compliance or FWA concern, and (c) implement appropriate corrective actions.

23. **Automatic Incorporation of CMS Requirements** - Provider agrees to incorporate into this Amendment such other terms and conditions as CMS may find necessary and appropriate, including amendments to CMS rules, regulations and guidance. Provider also agrees to incorporate into its Downstream Entity contracts all terms and conditions contained herein.

24. **Delegation**– Health Plan may only delegate activities or functions to Provider in a manner consistent with CMS rules and regulations.

25. **Delegated Activities** - Health Plan 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.

26. **Delegated Responsibilities** - 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 Amendment. 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 Amendment. If Provider determines his/her 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 action plans, to Health Plan upon request. Health Plan 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 Health Plan on an ongoing basis. Provider shall participate in and comply with Health Plan'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 Health Plan or CMS; participating in monitoring reviews; and providing Health Plan 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 Health Plan or CMS, Health Plan shall retain the right to revoke such delegation in accordance with Termination for Cause provisions set forth herein.

27. **Provider's Agreements with Downstream Entities** - To the extent that Provider delegates responsibilities under this Amendment, the following specifications or provisions shall be incorporated into its written agreements with such Downstream Entities:

    A. A description of the delegated activities and reporting responsibilities;

    B. A provision for the revocation of delegated activities and reporting requirements or other appropriate remedies in the event that CMS or Health Plan determines the delegate's performance is unsatisfactory;

    C. Specification that the Downstream Entity's performance is monitored by Health Plan on an ongoing basis;

D. Specification that credentials review process for all medical professionals affiliated with the Downstream Entity will be conducted by Health Plan or reviewed and approved by Health Plan and audited by Health Plan on an ongoing basis; and

E. A specification that the Downstream Entity must comply with all applicable federal laws, regulations and HHS instructions.

28. **Audit Compliance** - Provider shall, and shall require their Downstream Entities to annually attest to compliance with the following Sections in the Agreement: (a) "No Adverse Actions or Investigations," (b) "No Criminal Conviction or Civil Judgments," (c) No Excluded or Debarred Individuals," and (d) "Notice of Change of Circumstances." Health Plan 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 Health Plan with any information necessary for Health Plan 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 Health Plan in documenting compliance with this provision, including but not limited to, supplying attestations as required in this Section.

29. **Term and Termination** – This Amendment shall exist concurrently with the Agreement and Health Plan's Medicare Advantage Contract and shall expire upon termination of either contract. Subject to Continuation of Benefits provisions set forth herein, this Amendment may be terminated without otherwise affecting continuation of the Agreement:

    A. **Termination Without Cause** - The Amendment may be terminated by either party with or without cause upon sixty (60) days prior notice to the other party.

    B. **Termination for Cause** - The Amendment may be terminated by either party in the event of a material breach by the other party. Such termination may be effected upon thirty (30) days prior notice, provided the breaching party has been given reasonable time and opportunity to cure the breach.

    C. **Automatic Termination** – The Agreement shall automatically terminate in the event that:

        i. Provider is debarred, excluded from or opts out of participation in the Medicare program.

        ii. Health Plan's contract with CMS to offer a Medicare Advantage product terminates or expires.