MICHIGAN STATE PROGRAMS
REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MICHIGAN STATE PROGRAMS DOWNSTREAM PROVIDER REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between United Behavioral Health, (Subcontractor) and the party named in the agreement (the "Provider").

The requirements of this Appendix apply to Michigan Medicaid Assistance Program ("Medicaid"), Michigan MIChild Children's Health Insurance Program (referred to in this Appendix as "CHIP"), and/or Michigan Children's Special Health Care Services ("CSHCS") benefit plans sponsored, issued or administered by UnitedHealthcare Community Plan, Inc. ("Health Plan") under the State of Michigan's Medicaid, CHIP and/or CSHCS program ((the "State Program(s)") as governed by the State's designated regulatory agencies and pursuant to one or more of Health Plan's contracts with the State to provide covered services to members which is synonymous with the definition of Customers or Members (referred to in this Appendix as "Customers") as described in the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law.

Capitalized terms used but not defined in this Appendix shall have the meaning ascribed to them in the Agreement.

Provisions applicable to the Benefit Plans regulated under Michigan State Program rules or guidelines:

1. **State Programs Covered Services**. Provider agrees to provide those covered services to Customers that are covered by Health Plan in connection with the Medicaid, CHIP and/or SCHCS benefits. Provider further agrees to the extent required to furnish such services in accordance with the Health Plan's and/or Subcontractor's protocols pertaining to in-network referrals, prior authorization and Medical Necessity requirements.

2. **Medical Necessity**. Provider agrees to comply with Health Plan's and/or Subcontractor's Medical Necessity requirements. For purposes of the Agreement and this Appendix, the parties agree that Medical Necessity means covered services furnished by the Provider which are required to identify, treat or avoid an illness or injury to a Customer, which as determined by the Health Plan's and/or Subcontractor's Medical Director or designee or Health Plan and/or Subcontractor's utilization management process for the purposes of payment only, are (i) consistent with the symptoms or diagnosis and treatment of the Customer's condition, disease, ailment or injury; (ii) appropriate with regard to standards of medical practice; (iii) not primarily for the convenience of the Customer, the Customer's attending or

treating physician, or another health care provider; (iv) and the most appropriate supply or level of service which can be safely provided to a Customer.

3. **Excluded Provider.** Provider shall not employ or contract with individuals on the current register of employers failing to correct an unfair labor practice pursuant to 1980 PA 278, MCL 423.321, et seq., or on any State or federal exclusions list and Health Plan and/or Subcontractor shall terminate the Agreement immediately in the event Provider becomes excluded or is terminated from Medicare or the Medicaid program of any state. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is debarred, suspended or otherwise excluded from participating in federal health care programs under either Section 1128 or section 1128A of the Social Security Act. Additionally, Provider shall cooperate with Health Plan and/or Subcontractor in disclosing information the State may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106.

4. **Governmental Agency Access.** Provider shall permit the authorized government and regulatory agencies, to periodically conduct on-site evaluations of Provider's facilities, offices and records in accordance with the terms of this Agreement and current state and federal laws and regulations. Provider further agrees to comply with those agencies' recommendations, if any. Health Plan and/or Subcontractor shall give Provider reasonable notice of its intent to conduct a site visit and will give Provider reasonable notice of any agency's plans to conduct a site visit, if Health Plan and/or Subcontractor receives such notice. Provider shall further submit to medical audits conducted at the discretion of authorized government and regulatory agencies, which may include the copying of medical records or claims of Customers, as related to the standard of medical practice, billing and claims practice and quality of care provided to all Customers. Such audits are to be performed periodically, under the direction of a licensed physician(s), as required by appropriate federal or state regulatory agencies. Provider agrees to furnish copies of the medical and claims records at no charge.

5. **Quality Assurance.** Provider warrants that all services related to the performance of the Agreement are completed by employees or facilities that are fully qualified to perform such services. Provider shall provide the Covered Services in a manner consistent with generally accepted medical or industry standards and further agrees to cooperate with Health Plan's and/or Subcontractor's quality assurance, utilization management and risk management activities and protocols. Provider agrees that the State and its authorized agents may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed under the applicable state contract. Provider shall allow for inspection by the State any records, systems or work performed by Provider's personnel that is pertinent to the applicable state contract.

6. **Customer Self-Determination.** Provider acknowledges that Customers have the right under state and federal law to make decisions regarding medical care, including the right to accept or refuse life-sustaining treatment. Provider agrees to comply with the Patient Self-Determination provisions of the Omnibus Budget Reconciliation Act of 1990 and state law to the extent these laws apply to services provided by Provider pursuant to the Agreement.

7. **Reporting of Communicable Diseases**. Subject to the law regarding physician patient privilege and communicable disease reporting, including, without limitation, MCLA 333.5114 and 5114a, as amended, Provider agrees to submit to Health Plan and/or Subcontractor, the local health department and, when necessary, the Michigan Department of Health and Community Services a confidential report of a Customer's contraction of a communicable disease or a serious communicable disease or infection. In the event Provider determines that a Customer has a serious communicable disease or infection, Provider agrees to report such occurrence to the local health department and/or the Michigan Department of Health and Community Services, if required by law, not more than 24 hours after making the determination. A communicable disease and a serious communicable disease or infection are defined in accordance with MCLA 333.5101(b) and (g).

8. **Records.** Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements. Provider shall maintain such records for a period not less than seven (7) years from the close of the Agreement or such other period as required by law. In addition, if the records are under review or audit, they shall be maintained until the review or audit is complete.

9. **Oversight and Monitoring.** Health Plan and/or Subcontractor shall perform ongoing monitoring of services rendered by Provider, shall perform periodic audits and formal reviews of Provider consistent with the requirements of the applicable state contract and State and federal law and regulations. In the event Health Plan and/or Subcontractor identifies deficiencies or areas for improvement, Provider shall take appropriate corrective action to address such deficiencies, concerns or recommendations for improvement. Additionally, Provider shall cooperate fully with Health Plan's and/or Subcontractor's policies and the Deficit Reduction Act of 2005 (DRA) to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the state contract and shall cooperate and assist Health Plan and/or Subcontractor, and any State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

10. **Confidentiality.** Provider shall use reasonable care to prevent disclosure of non-public confidential information to third parties, and will limit disclosure to authorized personnel only, which includes but is not limited to any information that is held in confidence by the State under applicable laws or is marked confidential, restricted,

proprietary, or with a similar designation. Upon termination of the Agreement, Provider shall promptly destroy all confidential information. Provider's obligation to protect confidential information shall survive any termination of the Agreement.

11. **Marketing Materials.** As required under State or federal law or the applicable state contract, any media releases or marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan and/or Subcontractor to submit to the State for prior approval.

12. **Insurance.** Provider shall maintain during the term of the Agreement general liability insurance, professional liability insurance, vehicle liability insurance, employer liability and workers' compensation insurance for all employees connected with the provision of services under the Agreement, as applicable. Such workers' compensation insurance shall comply with Michigan's Workers' Compensation Law. Such comprehensive general liability, professional liability insurance and other insurance, as required, shall provide coverage in an amount established by Health Plan and/or Subcontractor pursuant to the Agreement or as required under applicable State law or state contract.

13. **Compliance with Michigan State Contracts**. All tasks performed under the Agreement must be performed in accordance with the applicable state contract, the provisions of which are incorporated into the Agreement as applicable. Nothing in the Agreement shall relieve Health Plan of its responsibility under the state contracts. If any provision of the Agreement is in conflict with provisions of such state contracts, the terms of the Agreement in conflict with those of the state contracts will be considered waived.

14. **UnitedHealthcare Community Plan, Inc.'s Claims Payment Obligations**. UnitedHealthcare Community Plan, Inc. and/or Subcontractor (as applicable) shall only be responsible for the payment of claims in connection with the covered services furnished by the Provider to UnitedHealthcare Community Plan, Inc.'s Customers pursuant to the terms and conditions of the UnitedHealthcare Community Plan, Inc.'s Michigan HMO license and the Agreement. UnitedHealthcare Community Plan, Inc. and Provider shall comply with the applicable prompt payment and clean claim provisions of Michigan Compiled Laws, §500.2006, as amended. UnitedHealthcare Community Plan, Inc. and Provider acknowledge and agree that UnitedHealthcare Community Plan, Inc. and Subcontractor are prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to UnitedHealthcare Community Plan, Inc. and/or Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

15. **Clean Claim and Third Party Liability (TPL)**. Health Plan and/or Subcontractor shall pay Provider pursuant to MCL 400.111i; 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable.

Health Plan and/or Subcontractor shall pay Provider for the Covered Services rendered to Health Plan's Customers in accordance with Health Plan's and/or Subcontractor Payment Policies and Protocols. The parties acknowledge and agree that the State Programs are payers of last resort when a covered person is covered by a State Program and another payer (e.g., Medicare). In the event that a covered person's covered services expenses are eligible, in whole or in part, to be paid by any governmental program, other than by Medicaid and CHIP, or by a public or private insurance or benefit plan (collectively, "third party payors"), the parties agree that payment shall be coordinated through primary and secondary payment responsibility with such other third party payers pursuant to federal and state third party liability statutes and regulations including 42 C.F.R. 433.135-139, MCLA 400.106(1)(b)(ii), MCLA 500.3440, as amended, MCLA 500.3101 et seq., as amended (Michigan No-Fault Law) and the Michigan Workers' Compensation Disability Act of 1969, as amended. Unless Health Plan and/or Subcontractor otherwise requests assistance from a Provider, Health Plan will be responsible for third party collections conducted in accordance with these guidelines.

16. **Governing Law**. The parties agree that the Agreement and all attachments, including this Appendix, shall be governed by and construed in accordance with the laws of Michigan.

17. **Additional Subcontractor and Health Plan Obligations**. Health Plan and/or Subcontractor shall adhere to the following obligations as may be required by federal or state law:

a. Health Plan and/or Subcontractor shall not prohibit or otherwise restrict Provider from discussing the Customer's health status, medical care, or treatment options, including any alternative treatment that may be self-administered that may not reflect Health Plan's and/or Subcontractor's position or may not be covered by Health Plan's Benefit Plan.

b. Health Plan and/or Subcontractor shall not prohibit or otherwise restrict Provider from providing any information the Customer needs in order to decide among all relevant treatment options.

c. Health Plan and/or Subcontractor shall not prohibit or otherwise restrict Provider from discussing the risks, benefits, and consequences of treatment or non-treatment with Customer.

d. Health Plan and/or Subcontractor shall not prohibit or otherwise restrict the Customer's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

e. Health Plan and/or Subcontractor shall not prohibit Provider from discussing financial arrangements between the plan and the Provider.

f. Health Plan and/or Subcontractor shall not prohibit a Provider from advocating on behalf of the Customer in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.

g. Health Plan and/or Subcontractor shall not discriminate with respect to participation, reimbursement or indemnification as to any provider who is acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of such license or certification. However, the foregoing provision should not be construed as an "any willing provider" clause, as it does not prohibit Health Plan and/or Subcontractor from limiting Provider to the extent necessary to meet the needs of the Customers. Provider acknowledges that the foregoing provision does not interfere with measures established by Health Plan and/or Subcontractor that are designated to maintain quality and control costs consistent with the responsibility of the organization.

18. **Customer Hold Harmless Clause.** Provider shall look only to Health Plan and/or Subcontractor for compensation for Covered Services rendered to a Customer when such services are covered by the Plan. Provider or any representative of Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Customer or persons acting on behalf of Customer (other than Health Plan or Subcontractor). Provider agrees and acknowledges that Covered Services shall not be withheld from the Customer to the extent that any copayments may be owed, nor when the Customer has an inability to pay. Provider agrees not to maintain any action at law or in equity against a Customer to collect sums that are owed by Health Plan and/or Subcontractor to Provider under the terms of this Agreement, even in the event Health Plan and/or Subcontractor fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Customers. This Section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to Non-Covered Services. Provider further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between Provider and Customer or persons acting on behalf of Customer, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

19. **Transition of Covered Persons.** Provider shall cooperate with Health Plan and/or Subcontractor in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Customer's health or safety is in jeopardy, as may be required under law.

20. **Continuity of Care.** Provider shall cooperate with Health Plan and/or Subcontractor and provide a Covered Person with continuity of treatment, including coordination of care to the extent required under law, in the event Provider's participation with Health Plan and/or Subcontractor terminates during the course of a Covered Person's treatment by Provider.

21. **Customer's Grievance, Appeal and Fair Hearing Procedures.** Health Plan and/or Subcontractor' shall not prohibit a Provider from advocating on behalf of a Customer in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services. Provider may find additional

information regarding Customer's grievance, appeal, and fair hearing procedures and timelines in the Health Plan's and/or Subcontractor's Member Handbook which is available at http://www.uhccommunityplan.com.

22. **Cultural Competency.** Provider shall participate in Health Plan's and/or Subcontractor's, and the State's efforts to promote the delivery of services in a culturally competent manner to all Customers, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Provider shall provide information to Customer regarding treatment options and alternatives in a manner appropriate to the Customer's condition and ability to understand.

23. **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Health Plan and/or Subcontractor.

24. **Additional Provider Obligations.** Provider shall adhere to the following obligations as may be required by federal or state law:

    a. Provider shall ensure Customers are not denied a Covered Service or availability of a facility or provider identified in the state contract.
    b. Provider will not intentionally segregate enrollees in any way from other persons receiving health care services.